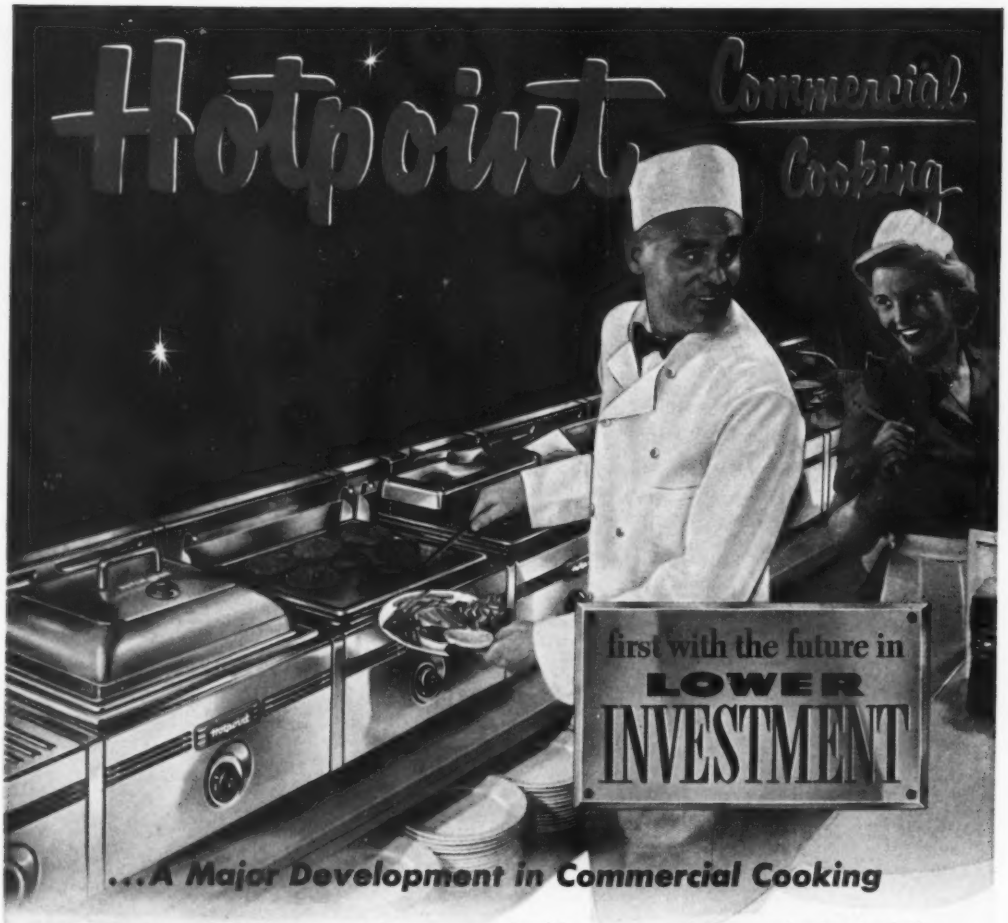
The Modern Hospital

AUGUST 1952

Hospital-in-the-Round • Employe Credit Unions • How to Use the Nursing Team • Current Report on Negroes in Medicine • Analyzing the Hospital's Insurance Coverage • Have Your Own Laundry Menu Planning in the Small Hospital • Paging Doctors by Radio •



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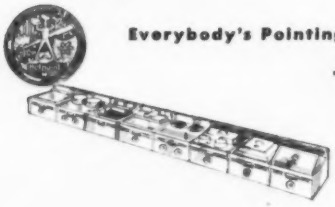

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Dr. Franklin C. McLean is secretary-treasurer and guiding spirit of National Medical Fellowships, Inc., Chicago foundation, formerly known as Provident Medical Associates. The foundation devotes all its resources to the provision of educational opportunities to qualified Negro doctors and medical students. Now in its sixth year, it is embarking on an expanded program of scholarship aid and is receiving wider support than ever before. Dr. McLean is professor of pathological physiology at the University of Chicago, where he has been a member of the medical faculty since 1923. A graduate of Rush Medical College, Dr. McLean was professor of medicine at Peiping Union College, Peiping, China, for seven years before returning to the University of Chicago. Mrs. Hilda Reitzes, co-author with Dr. McLean and Dr. N. O. Calloway of the article on opportunities for Negroes in medicine on page 68 of this magazine, is fellowship secretary of National Medical Fellowships, Inc. Mrs. Reitzes was a member of the staff of the Julius Rosenwald Fund for several years and administered its fellowship program. Dr. Calloway, a major in the army medical corps, is assistant chief of the medical service at Percy Jones Army Hospital, Battle Creek, Mich. He is also assistant professor of internal medicine at the University of Illinois medical school and executive director of National Medical Fellowships, Inc. He was formerly medical director of Provident Hospital, Chicago.

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John H. Gorby, author of the article on employe credit unions on page 55, is administrator of the La Mesa Community Hospital, La Mesa, Calif. Mr. Gorby was graduated from the school of business administration of the University of California at Los Angeles, then spent 15 years as a public accountant, specializing in hospital finance and accounting problems. He has been director of the Southern California Hospital Council and president of the Hospital Council of San Diego County.

Harry Becker

Harry Becker, whose thought provoking paper on the future of Blue Cross and hospital financing appears on page 94, is associate director of the Commission on Financing Hospital Care, a position to which he was appointed last winter after he had served for four years as director of the social security department of the United Automobile Workers, C.I.O. Mr. Becker was for five years director of the administrative methods unit of the U.S. Children's Bureau and, earlier, technical adviser in medical care administration, U.S. Public Health Service.

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Roving Reporter

We Invited the Community In

We believed the community would be interested in the "inside" of hospital operation, so we offered it the chance when we dedicated the additions to St. Luke's Hospital in Boise, Idaho.

We had long thought that hospital public relations would be bettered if more people could see how we function and could lose their fear of the hospital as a strange, mysterious place. Too, we felt that the citizens of this city of 34,000 would like to see how we had spent the money they contributed in a public fund drive.

We got our answer; they would, and they did! We hoped for a thousand—nearly 4000 came!

For two weeks prior to the event, local newspapers cooperated with a generous use of material on the hospital. Local radio stations worked with hospital personnel in preparing tape recordings, which were broadcast before the event. Emphasis was placed on our plan to demonstrate how a hospital works in all advance publicity. Photographs of departments in actual operation were used. Hospital employes on all levels were featured in publicity, with pictures and information about every department.

The story of the hospital itself started in 1902, when the Rt. Rev. James B. Funsten, Episcopal missionary bishop of Idaho, handed Lillian Long $600 and said, "There, now you can start your hospital."

From a bed capacity of six, the institution was enlarged four times by 1906. In 1913, a wing was built that is still in use. The hospital had turned repeatedly to the church members, and, increasingly, to the community, for funds to meet the hospital needs of this fast-growing city. The community continued to help when, in 1928, several former structures were razed and the present main building was erected.

Once again, in 1947, the hospital went to the community for funds, this time in an unusual and revolutionary move. Boise has only two local hospitals (there is a Veterans Administration hospital here also), both church sponsored. Both were contemplating fund drives for needed expansion. The hospitals decided to join forces, each contributing funds already raised separately, and a joint drive was conducted. Equal division was made of the more than $900,000 subscribed.

Skyrocketing costs of building delayed the start of construction until additional funds were subscribed, but ground was broken in April 1950, and the actual building took nearly two years.

We had felt the continuing community concern over the slowness of construction; so much time had elapsed since the fund drive that we were doubtful whether much interest in the finally completed project would be shown. Hospital Day programs during the building program had met with little success. We approached the whole open house idea with some trepidation, but we did feel that those interested should have the chance to see the results, so we went ahead.

We decided that the dedication of new facilities would be a small part

of the actual program. The real emphasis for the day was placed on our invitation to the public to visit the hospital, see the new additions, inspect all the facilities, and, most important, see how the hospital operates.

Every employe had a part in the observance. Departmental displays were developed by the persons actually employed in the department. Laundry workers assembled all the linens needed by a patient, and those who would care for him, for an average hospitalization for an appendectomy. Central supply arranged demonstration kits for various purposes. Dietary personnel prepared a display showing the daily diet, and all the trays that might be made up.

We incorporated the services of our woman's auxiliary, thereby giving a "social" edge to some publicity and gaining access to the woman's page of the local newspaper.

Advance tours, plus detailed mimeographed sheets directing guides to "Turn Left to First Floor Chart Station" and the like, were used to train the auxiliary members as guides for the day. Visitors were taken in groups of 20. In each department, the guide introduced the department employes in charge, and they, in turn, explained the functions of the department. Thus we utilized our lay workers, yet avoided the arduous training that would have been necessary to prepare them with accurate information about the entire hospital.

Demonstration in the orthopedic unit.

The unvarying enthusiasm of the visitors as they left the building convinced us of the value of this plan. Naturally, such a program requires a great deal of planning and coordination, but we carried it out in our 245 bed institution with every department in use and a maximum census. We know it can be done.

We know, too, that there are at least 4000 persons in this community who have seen how we work, who have tried an anethesia mask or handled a hemostat or watched a nurse turn a Foster frame and will be our good-will ambassadors from now on. Four thousand friends are worth a lot to any hospital.—NADIS C. CHAPIN, *director of public relations, St. Luke's Hospital, Boise, Idaho.*

Operation Smallfry

Operation Smallfry has been a morale builder for patients, their parents, and the medical and nursing staff at the U.S. Army Hospital in Fort Knox, Ky.

When Col. A. L. Tynes, commanding officer of the hospital, took over last summer, he observed the dreary aspect of the children's ward and the outpatient department, both of which served the soldiers' dependents. An $8,000,000 hospital project was a-building at Fort Knox, so Col. Tynes could put his hands on little money to remodel the children's facilities.

From the Armored School he found five artists—four corporals and a sergeant—who at his suggestion decorated the rooms that make up the chil-

dren's department with Walt Disney characters. They worked day and night till they finished.

Some 75 children a day visit the outpatient clinic for checkups, immunization shots, and minor ailments. A special corner of this clinic was reserved for children and it was furnished with children's furniture, hobby horses and bright juvenile draperies.

"There are two reasons for paying special attention to children who need a doctor's care," Col. Tynes told a *Louisville Courier-Journal* reporter who went out to check up on the project. "First, of course, is that they naturally need something more than the ordinary approach because they are children.

"The second reason is morale. Taking care of dependents is as important as taking care of the soldiers themselves. There's nothing harder on a soldier's morale than having a sick loved one for whom he is not sure of adequate medical care."

Since the completion of Operation Smallfry, "the personnel who work with the children feel more like they're doing pediatric work," Col. Tynes added. "It gives them just the added spark they need."

Reader Opinion

Medical Records

Sirs:

It must have come as something of a jolt to medical record librarians to read, in the resumé of the proceedings of the Western hospital meeting published in the June issue of The MODERN HOSPITAL, the following comments attributed to Dr. Lewis A. Alesen, president of the California Medical Association:

"Criticizing the unnecessary severity of medical records regulations, Dr. Alesen described the medical record librarian as a 'new type of medical aristocrat' who insists on too many technicalities and wastes too much of the doctor's time. The purpose of medical records is to provide the necessary information for proper patient care and to give both patient and doctor adequate legal protection, he said. Beyond these minimum requirements, he indicated, a great many presently required records procedures could be eliminated without loss."

Dr. Alesen has performed a valuable service by bringing forward a real problem which should receive serious and thoughtful consideration. Medical manpower is scarce and must be conserved. If unreasonable demands are being made of doctors to fulfill nonessential medical record requirements, this is a matter which should be brought to the attention of all those responsible for establishing medical record policy and regulations. The new Joint Commission on the Accreditation of Hospitals will have a particular interest in the problem, as it moves ahead with its program.

It is a thought provoking statement, too, for all medical record librarians, and may result in some cases in a healthy exercise in self-examination. The group as a whole, however, will want to try to determine whether the label "a new type of medical aristocrat" is justified, and if so, what has been done by medical record librarians to deserve it.

If indeed there is generally an unnecessary severity of medical record regulations, and if medical record librarians are in large measure responsible for the supernumerary requirements, they must accept the responsibility and do something about it.

A first consideration is to determine who is responsible for establishing policy and regulations concerning medical record requirements. Several groups have a hand in this. The hospital accreditation standards set certain basic requirements; other accrediting bodies have added special record requirements in connection with training in certain medical specialties. The medical record committee of the hospital recommends, and the hospital administrator adopts, policy and regulations for the individual hospital. It then becomes the responsibility of the medical record librarian, the medical record committee and the administrator to enforce the regulations adopted.

It would appear then that the medical record librarian cannot, alone, institute unnecessarily severe medical record

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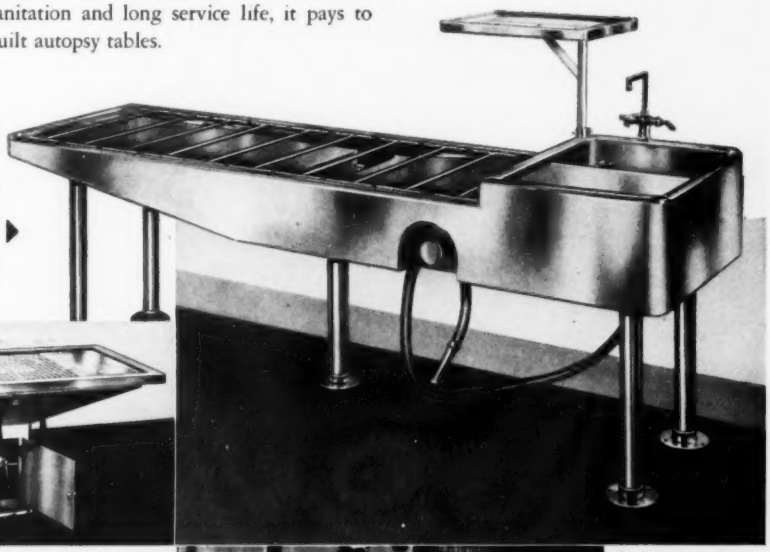

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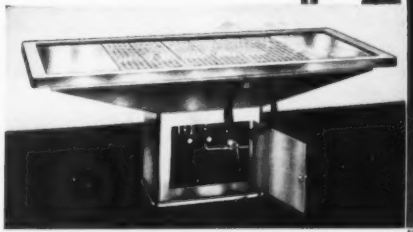

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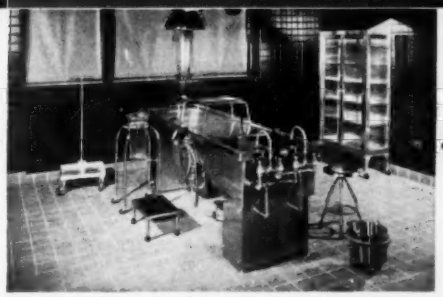

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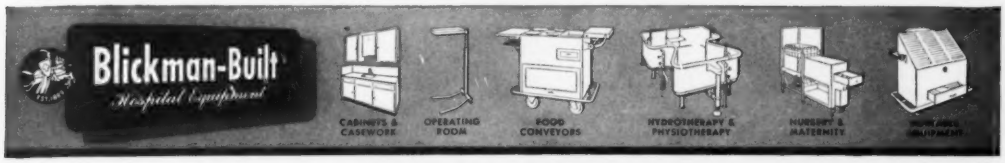

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regulations. She might recommend to the committee or the administrator, but in the normal hospital situation, she would not under any circumstances have the authority to establish a regulation.

If this is the case, then perhaps the criticism voiced by Dr. Alesen is related to a too rigid interpretation and enforcement of regulations, or a "reading into" the regulations a degree of refined detail that was not intended. Overzealous or unqualified medical record personnel may insist on such a minute adherence to the letter of the law, as distinct from its spirit or intent, as to drive the medical staff to distraction, giving it grounds to complain that the requirements are unnecessarily severe.

Or perhaps the methods used by some medical record librarians are unnecessarily time consuming, even though the additions or corrections sought are entirely proper. If they take a piecemeal approach to the physicians, and interrupt them frequently with queries, the irritations are magnified and the appearance rather than the fact of "too much for too little" results. The medical record librarian who organizes her work well, lists all the information needed from the physician, and presents it to him in such a manner as to permit him to give it his attention at his convenience, does not make the task onerous out of its proper proportion.

Medical record librarians traditionally have been regarded as "watchdogs" of the records. I feel sure that they do not enjoy either the title or the task. The medical record librarian wants to be and should be in all respects the doctor's *assistant* in matters *related to medical records*, not his monitor. The administrator of the hospital, however, has a right to expect her to carry out the responsibilities he has delegated to her in order to assure maintenance of required standards.

Perhaps it is time for *all* who are concerned with assuring good medical records to examine the requirements and regulations and to put each to the test: (1) Is this essential? (2) If it is not absolutely essential, does it actually contribute to the value of the medical record in serving its basic functions with respect to the patient, the physician and the hospital, including medical research? Such a reevaluation might be profitable and result in some simplifications and eliminations.

In addition, all medical record librarians should, as many do, examine their methods of carrying out their necessary duties, striving for a minimum of consumption of the doctor's time.

Last, but not least, medical record librarians should continuously study and try to provide ways to help doctors carry out their medical record tasks. More secretarial service, better dictating equipment, such innovations as central transcribing systems—these are but a few of the things that can save doctors' precious time.

The primary objective of training medical record librarians is to provide useful medical *assistants in the field of records*, with the emphasis on "assist"—not to create medical aristocrats or dictators. With this goal in mind, the medical record profession should join forces with the various accrediting bodies, with hospital administrators, and all others concerned, to do everything in their power to assure that medical record requirements are reasonable and justified, and that they are reasonably administered.

Helen D. McGuire
Chief, Medical Record Branch
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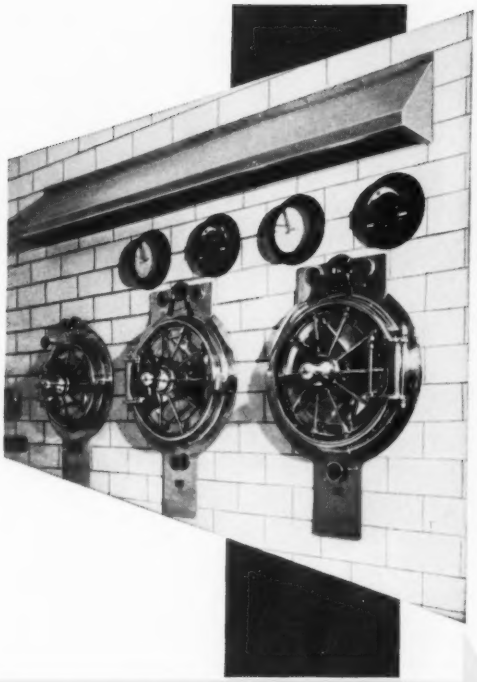

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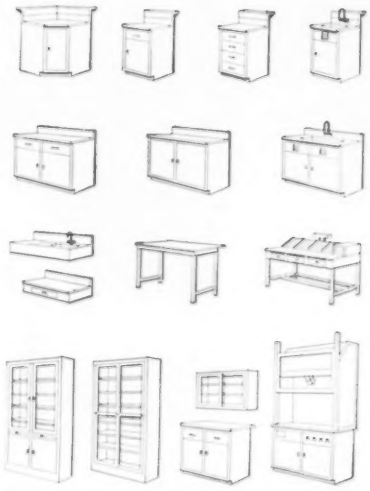

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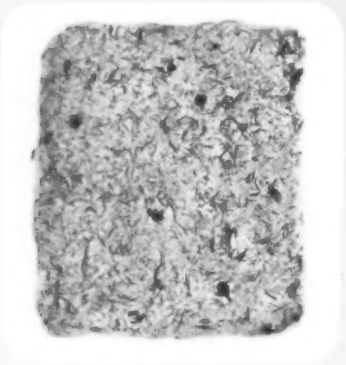
YOU COULD MAKE THIS SIMPLE TEST

Loops of gut were tied around a glass tube and immersed in 1% trypsin solution. After 200 hours (comparable to 6 months in tissue) the residue was spread on glass plates. Note the difference.



1. Ordinary surface chromicizing shows residue of undigested knots and suture fragments.

2. Tru-Chromicizing permits complete absorption, no undigested residue.

INDEX TO ADVERTISEMENTS

(HPF) after company name indicates that further descriptive data are filed in catalog space in HOSPITAL PURCHASING FILE—29th Edition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Personalized
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TRADEMARK
COAT OF ARMS
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DINACRIN®

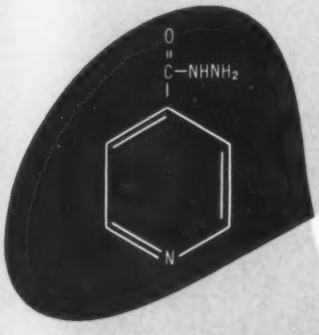
Brand of ISONIAZID
(isonicotinic acid hydrazide)

the new dramatic therapeutic development in tuberculosis

Clinical studies with isonicotinic acid hydrazide in streptomycin resistant cases have shown this compound to be a powerful drug against tuberculous infections. Its use in patients with pulmonary tuberculosis is frequently followed by rapid subsidence of fever, restoration of strength, development of ravenous appetite and marked weight gain. Cough and sputum are often considerably decreased or eliminated. X-ray changes indicating resorption of the exudative process, reduction of cavity size or closure occur in about half of the patients. Chemotherapeutic effects are also promising in extrapulmonary tuberculosis including orthopedic lesions.

Average dose: From 2 mg. to 4 mg. per kilogram body weight.

Available in tablets of 50 mg., bottles of 100 and 1000 tablets.



DINACRIN

Write for informative literature.

Winthrop-Stearns INC.
NEW YORK 18, N. Y. WINDSOR, ONT.

Dinacrin, trademark reg. U.S. Pat. Off.

708M

Greater patient comfort.

Drainage absorbs into the pad—immediately. Protects against running off the sides onto the bed linen.

Only TRI-PAD®*

DISPOSABLE UNDERPAD

has *all* these advantages

Masslinn* non-woven fabric and multiple layers of absorbent cellulose provide adequate capacity.

Wet or dry—sterilized or unsterilized—facing and repellent backing stand up under extreme tension.

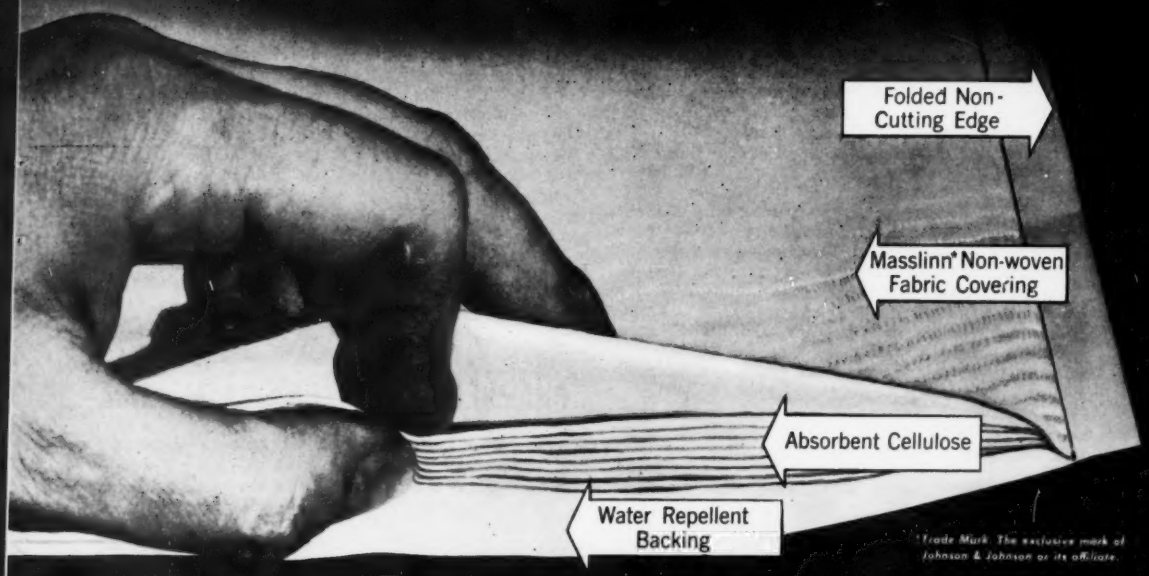
Less frequent linen changes—more time for more important duties.

and Laundry Burden

Sheets last longer with fewer changes—reduces laundry costs.

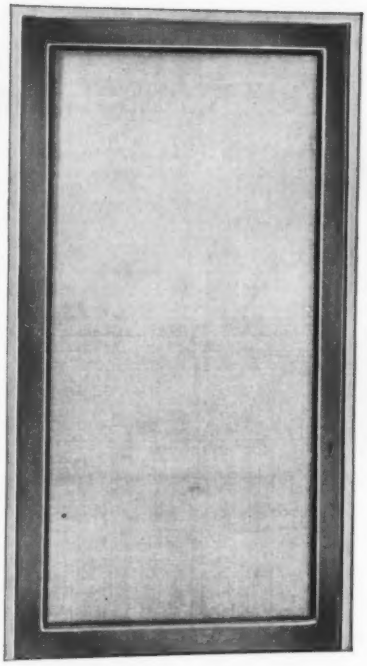
Eliminates waste of time and materials.

May be sterilized without affecting its usefulness.



*Trade Mark. The exclusive mark of Johnson & Johnson or its affiliates.

At right, your most economical, long-run security-screen buy! Chamberlin Security Screens are, pound for pound, the heaviest, strongest made. They provide extra-long life at lowest possible maintenance cost.



Neurological Building,
Philadelphia General Hospital

What Philadelphia General Hospital bought in its 2,201 Chamberlin Security Screens

For use in its recently completed Neurological Building, Philadelphia General Hospital bought 2,201 Chamberlin Security Screens—306 Detention-type, 1,410 Protection-type, 485 *special* Protection-type.

About the latter: At time of purchase, Philadelphia General needed only insect screens for rooms that would *later* house disturbed patients. To avoid the expense of replacing complete insect screens when change-over was made, 485 Chamberlin Protection Screen frames with aluminum *insect screen* cloth were installed at the recommendation of the Chamberlin Advisory Service.

As disturbed patients occupy rooms, simple, inexpensive switch to Chamberlin's heavy stainless-steel wire cloth provides needed detention strength of Chamberlin Screens, which also act as insect screens.

To the obvious savings above, add important yearly maintenance savings *and* top security-screen performance—and you know what Philadelphia General Hospital bought in its 2,201 Chamberlin Security Screens. Check these famous Chamberlin features against *your* needs:

PERFORMANCE—Chamberlin Security Screens deliver safe, sure, humane detention and protection year in, year out. That almost goes without saying.

SAVINGS—Chamberlin Security Screens deliver important yearly savings. For instance, their extra-heavy construction outlasts severe attacks, usual forcing, prying, picking. Repair bills go down, stay down. Too, Chamberlin Security Screens stop glass breakage, grounds littering; cut maintenance costs substantially.

ADVISORY SERVICE—Chamberlin Advisory Service will help you save every possible cent, as it has done for architects, contractors, and institutional managements during 14 years of specialization in this field. Write for informative folder on Chamberlin Security Screens—Detention, Protection, or Safety types. Or let us give you exact data on the specific security-screen needs you have in mind.

Modern institutions turn to

CHAMBERLIN

CHAMBERLIN COMPANY OF AMERICA

For modern detention methods

CHAMBERLIN COMPANY OF AMERICA

Special Products Division

1254 LA BROSSE ST. • DETROIT 32, MICHIGAN

CHAMBERLIN INSTITUTIONAL SERVICES also include Rock Wool Insulation, Metal Weather Strips, All-Metal Storm Windows, and Insect Screens

"AMERICAN" COVERS THE NATION

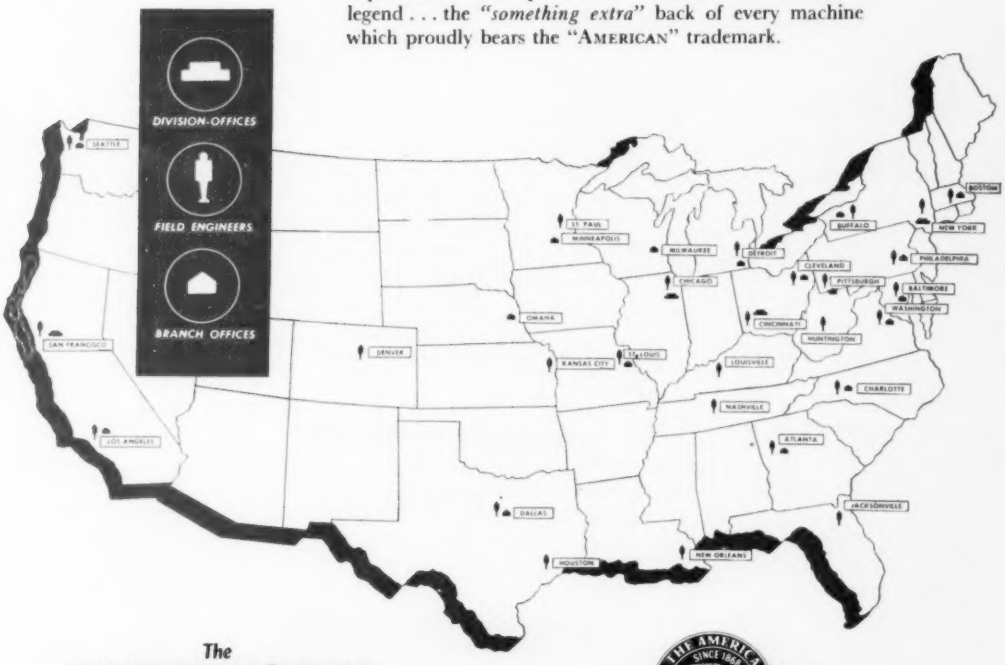
with Convenient, Dependable Service

Ready to serve hospitals and institutions everywhere, AMERICAN field engineers are spotted all over the nation, from coast to coast.

In some cities, as many as ten AMERICAN service engineers stand ready to respond to any call. In the field, other AMERICAN service engineers and technicians are in constant touch with their headquarters for assignment wherever needed.

In strategically located cities, AMERICAN also keeps a stock of repair parts for rush shipment in any emergency.

Among hospitals and institutions everywhere, AMERICAN'S nation-wide service and recognized reputation for dependable follow-up on each installation has become a legend . . . the *"something extra"* back of every machine which proudly bears the "AMERICAN" trademark.



The
AMERICAN
LAUNDRY MACHINERY CO.
CINCINNATI 12, OHIO

AMERICA'S MOST FAMOUS SOAP FITS THE HOSPITAL PICTURE PERFECTLY!

WE won't try to tell you that Ivory Soap was developed specifically for hospital use back in 1879. But if this *had* been our objective, we could scarcely have produced a soap better qualified to serve hospital needs, as its wide institutional acceptance today attests.

Two Ivory qualities have been chiefly responsible for the enthusiastic approval Ivory has won in your field — its superb purity and its gentle cleansing action. Couple these with Ivory's rich lathering qualities, freedom from irritating perfume, and its sheer attractiveness, and you understand why it stands high in hospital esteem.

Your patients, personnel, and visitors will appreciate "Ivory Service." And you can provide it without undue strain on your budget.

Procter & Gamble
CINCINNATI, OHIO

99 44/100% Pure . . . It Floats

● Pure, gentle Ivory Soap is available for hospital use in the widely-used 3 ounce size (Packed weight) as well as in four smaller sizes — wrapped or unwrapped.

● MORE DOCTORS ADVISE IVORY SOAP THAN ALL OTHER BRANDS TOGETHER!

Rx for Good Windows

This 60-bed privately owned hospital is completely modern — in design, materials and equipment. Everything possible has been planned for the patient's welfare — and at the same time offset today's high operational costs.

Lupton "Master" Aluminum Windows play a major part. Their attractive appearance would be enough to recommend them — but they offer far more than beauty. The aluminum frames will never need painting. Ventilators will always operate freely and easily, never get paint clogged.

Open-in ventilators at the bottom direct air to the ceiling — no drafts can strike the patients. The main ventilators open out, act as a weather shield.

Screens are clipped right to the windows, installed from within the building. Window cleaning is an inside job too.

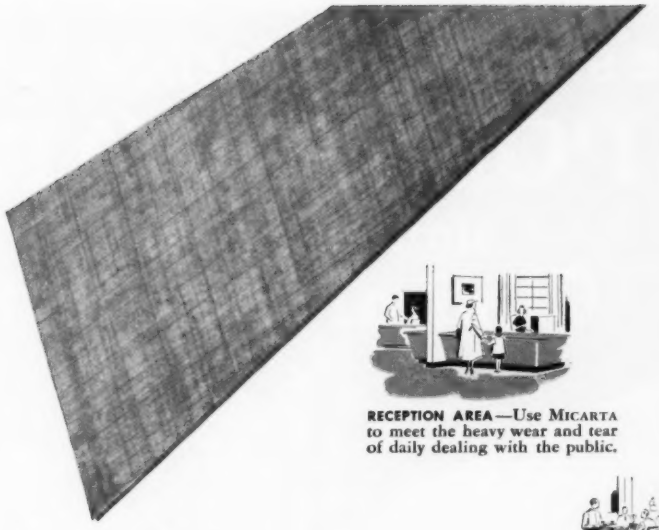
Initial cost is moderate — but when you figure exceptional long life and no maintenance, you'll find Lupton "Master" Aluminum Windows the most economical buy you can make.

For complete details see the local Lupton Representative — or write direct to us.

MICHAEL FLYNN MANUFACTURING CO.
700 East Godfrey Avenue, Philadelphia 24, Penna.
Member Metal Window Institute and Aluminum Window Mfrs. Assoc.

The Olney Hospital & Lawncrest Diagnostic Clinic, Philadelphia, Pa. Lupton "Master" Aluminum Windows are used throughout this new private hospital. Another modern feature planned by the architect, Henry S. Berg of Philadelphia, is the lack of interior stairs. Gently sloping ramps lead between the floors. Transfer of patients is quick and simple without the expense of an elevator.

LUPTON
METAL WINDOWS



RECEPTION AREA—Use MICARTA to meet the heavy wear and tear of daily dealing with the public.

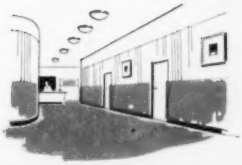
Why micarta PLASTIC SURFACE belongs in hospitals

STAFF CAFETERIA—Use MICARTA to deal with sliding dishes, spilled liquids, grease and food stains.

MICARTA® belongs in hospitals because it will bear the brunt of the heaviest kind of institution traffic for a lifetime and yet remain clean, bright, scar-free and sanitary. This amazingly tough, laminated plastic surface resists scuffs, scrapes, stains, or burns. It wipes to a gleam with a damp cloth.

There are MICARTA colors and patterns to blend with every hospital interior. The pleasing, clean-appearing surfaces promote an atmosphere of confidence and efficiency which is so important to the morale of patient and visitor alike.

Whether you are building or remodeling, MICARTA can work wonders in areas of hard usage where more conventional materials will deteriorate. You can use MICARTA wherever the job calls for the perfect combination of smart appearance and lasting utility. Consult your architect on MICARTA, or call your nearest U. S. Plywood representative. For further information on MICARTA properties and applications just fill out the coupon below.



WAINSCOTING—Use MICARTA to handle the business end of bumps in corridors and heavy work areas.

FURNITURE—Buy MICARTA-topped hospital furniture for freedom from maintenance problems.

Westinghouse micarta®

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J-06485

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Please send full information on MICARTA and its applications.

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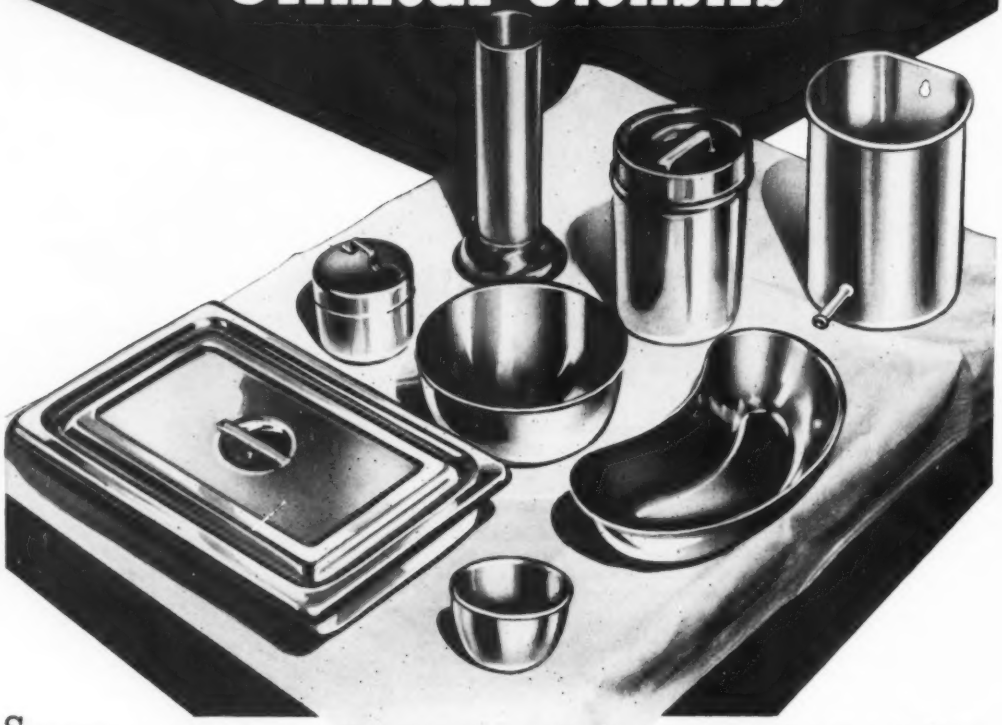
MH-8-52

There's *extra protection* for you in POLAR WARE stainless steel Clinical Utensils



SEAMLESS construction in Polar Ware stainless steel provides an extra measure of assured sterility in washing. This plus value is reinforced by many other positive qualities in these almost indestructible clinical utensils. Antiseptics, medicines, soaps, detergents affect them not at all. Neither do high or low temperatures. In a phrase, these ever-lasting advantages offer you a bedrock economy of maintenance unmatched by anything else that you buy.

The doctor in the operating room, the pharmacist in the dispensary, the patient in the sickroom, all accept these clinical utensils with a confidence anchored on years of time-tested performance. Polar Ware has pioneered this recognition . . . has since 1926 produced stainless steel ware to the exacting requirements of hospital service. No other manufacturer has known this specialized field longer, or better — or provides a more complete line. That's why the leading supply houses from coast to coast feature Polar Ware. They make it their business to give you the best. Ask the men who call on you.

A catalog showing the complete Polar Ware line is yours for the asking.

Polar Ware Co.
4300 LAKE SHORE ROAD · SHEBOYGAN, WISCONSIN

No other window—only **RUSCO** gives you these 6 important advantages

1 EXCLUSIVE MAGICPANEL® VENTILATION CONTROL—a simple adjustment that provides *rainproof, draft-free, filtered-screen ventilation* all year 'round, regardless of weather!

2 BUILT-IN WATERPROOFED FELT WEATHERSTRIPPING. Makes Rusco Windows completely weathertight, eliminates metal-to-metal contact, noise and rattling.

3 POSITIVE AUTOMATIC LOCKING in all open and closed positions. Springbolt action.

4 SMOOTH, EFFORTLESS OPERATION. Rusco sash sections slide up and down in a felt cushion—easily, quietly, without effort.

5 MADE OF TRIPLE-PROTECTED GALVANIZED STEEL for strength, long life and minimum maintenance. Zinc-treated, Bonderized and finished with baked-on outdoor enamel for protection against weathering.

6 GLASS PANELS REMOVABLE FROM INSIDE FOR EASY CLEANING. Upper and lower glass inserts slip out in an instant for safe, convenient, inside cleaning.

For New Construction...

The RUSCO Prime Window

A completely pre-assembled window unit containing glass, screen, weatherstripping, insulating sash (optional) and wood or metal surround. Comes fully assembled, factory-painted, ready to install. Makes big savings in time and labor.

For Weathertight Modernizing...

The RUSCO *Self-Storing* Combination Screen & Storm Sash

Installed without any alteration to present windows. Completely weatherproofs window opening. Provides rainproof, draft-free, filtered-screen ventilation in every kind of weather. The world's best-accepted combination window—over 8,000,000 already installed.

The Beautiful, Sturdy RUSCO Galvanized Steel Combination Screen and Storm Door

Handsome *and* practical! Made of sturdy triple-protected galvanized steel and finished with baked-on outdoor enamel. Won't sag, bind or warp. Lumite screen withstands abuse, can't rust or rot, never needs painting. Self-storing arrangement provides full glass insulation with lower screen for ventilation, as desired. Or, door can be converted *in seconds* to all glass or all screen!

These are just a few of the many Hospitals using RUSCO products:

Mercer Cottage Hospital, Mercer, Pa. • The Huntington County Hospital, Huntington, Ind. • Tecumseh Hospital, Tecumseh, Nebraska • St. Elizabeth's Hospital, Youngstown, Ohio • Nantucket College Hospital, Nantucket, Mass. • Mercy Hospital, Auburn, New York • New England Hospital for Women & Children, Roxbury, Mass. • Newport Naval Hospital, Newport, Rhode Island • Valley View Sanatorium, Haledon, New Jersey.

For full information see your local Rusco Dealer, or write direct to

The F. C. RUSSELL CO.

World Leader in Window Conditioning

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the *Ultimate* in NURSES' CALL SYSTEMS

Couch AMPLIFIED NURSES CALL

... brings to its ultimate refinement the electronic nurses' call ... with more features that appeal to hospital management, the nurse, and the patient.

1 Complete two-way communication between the nurse on duty and all rooms, permits more nursing, less walking.
2 Crystal-clear Couch circuits transmit voices distinctly, without distortion and free of background noise.
3 Sensitive ***dual***-volume control allows nurse to hear the softest voice ... without amplifying the nurse's reply.
4 Couch's "All-Call" feature monitors all rooms simultaneously ... at the flick of a switch.
5 Compact and attractive, the master station is a space-saving addition to the nurse's desk.

Contractors & Architects, note: Room stations fit standard electrical outlets, require no "special" installations. Get the details in Bulletin 528.

Simplified Systems of Communication

S. H. Couch Company, Inc.

Private telephones for home and office ... hospital signaling systems ... apartment house telephones and mail boxes ... fire alarm systems for industrial plants and public buildings.

NORTH QUINCY 71, MASSACHUSETTS, U. S. A.

Full selection of Cones AT YOUR FINGER TIPS

Long or short, big or small, wide or narrow — Westinghouse has a cone for virtually every radiological need. We have deep, intermediate and superficial therapy cones, in dozens of shapes and sizes for dozens of applications. And every cone you buy from Westinghouse is precisely designed for accuracy of beam position, patient protection, field size, and other important factors.

Therapy accessories are as important to good results as the X-ray machine itself. In addition to cones, Westinghouse carries a complete line of filters, adapters, and localizers—all accepted as industry standards . . . all carefully designed and made with a precise knowledge of your radiological needs.

See your local Westinghouse representative for full information on cones. To obtain a complete listing of all Westinghouse X-ray accessories, write the Westinghouse Electric Corp., X-ray Accessories Section, 2519 Wilkens Ave., Baltimore 3, Md.

WESTLINE CABINETS X-ACTRON PORTABLE UNITS TUBESTANDS MONOFLEX PFX FLUORADEX DUOCONDEX SERVICE ACCESSORIES

YOU CAN BE SURE... IF IT'S

Westinghouse

J-06854

MEDICAL X-RAY

Angelica... for *all* hospital apparel

operating gowns that LAST...and last!

Thorough Research Makes Angelica First in Hospital Apparel Development Since 1878

If you're interested in hospital apparel that will save money . . . choose Angelica. "On duty" for over 70 years, Angelica apparel has met every requirement in surgery, the wards, dietary and maintenance.

To over 5,000 hospitals from coast to coast, the name Angelica stands for fine workmanship, exclusive materials and quality money-saving apparel.

Angelica operating gowns have been "task-tested" to assure sterile coverage and complete freedom of movement for the surgeon. These outstanding garments are available in a wide range of materials, including Monte Cloth which has been proven over 25% longer-lasting in hospital tests.

For lower costs throughout your hospital . . . call your Angelica representative.

Angelica UNIFORM COMPANY

1427 Olive, St. Louis 3 — 177 N. Michigan, Chicago 1
107 W. 48th, New York 19 — 1101 S. Main, Los Angeles 15
427 St. François Xavier St., Montreal

Ideal INTERCHANGEABLE SYRINGES

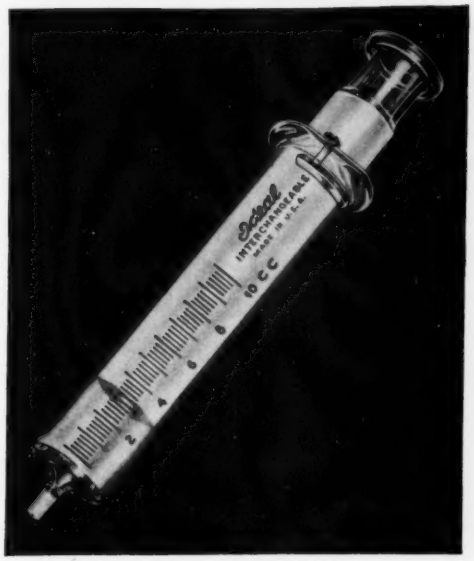
The great improvements and many advantages of a syringe with perfected interchangeable barrel and plunger are obvious. If either barrel or plunger becomes broken it is now possible to order only the broken part, with complete confidence that a perfect fit will result between the old part and its new companion piece.

Combining our newly patented Embedded Indelible Graduations* with a perfected system of interchangeable parts we have produced a syringe which is as perfect as a syringe can be.

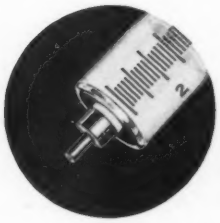
Barrel and plunger are of Kimble Resistant glass famous for its ability to withstand deterioration under repeated sterilization and also to resist sudden thermal changes. Scientific annealing eliminates any breakage due to internal strains.

Any Ideal Interchangeable Plunger plus any Ideal Interchangeable Barrel of same size equals a complete Ideal Interchangeable Syringe with *perfect fit*.

* Protected by U. S. Patent No. 2505411 April 25, 1950

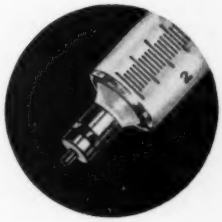


No longer is it necessary to painstakingly match serial numbers on plungers and barrels. With perfected interchangeable parts any plunger and any barrel of identical size can quickly and easily be assembled with assurance of perfect fit.



Minimum breakage and safety of operation are the salient characteristics of this Ideal *Interchangeable* Syringe, equipped with Luer-gauged Metal Tip.

The Ideal *Interchangeable* Syringe with *permanently* attached, positive-locking tip is especially advantageous in spinal and tonsil work.



EMPIRE STATE THERMOMETER CO., Inc.

10 WEST 33rd STREET • NEW YORK 1, N. Y.

"Vinylast" Floor Tile illustrated, manufactured by Vinyl Plastics Inc., Sheboygan, Wis.

floor stamina ...
HIGH!

floor maintenance...
LOW!

The scuffing, busy feet of energetic youngsters, or the heavy, pounding tread of golfers – often with shoe spikes—cannot hurt the surfaces of these floors.

Why? Because they're floor coverings made with VINYLITE Brand Resins. They stand up year after year —surfaces and colors stay fresh as new!

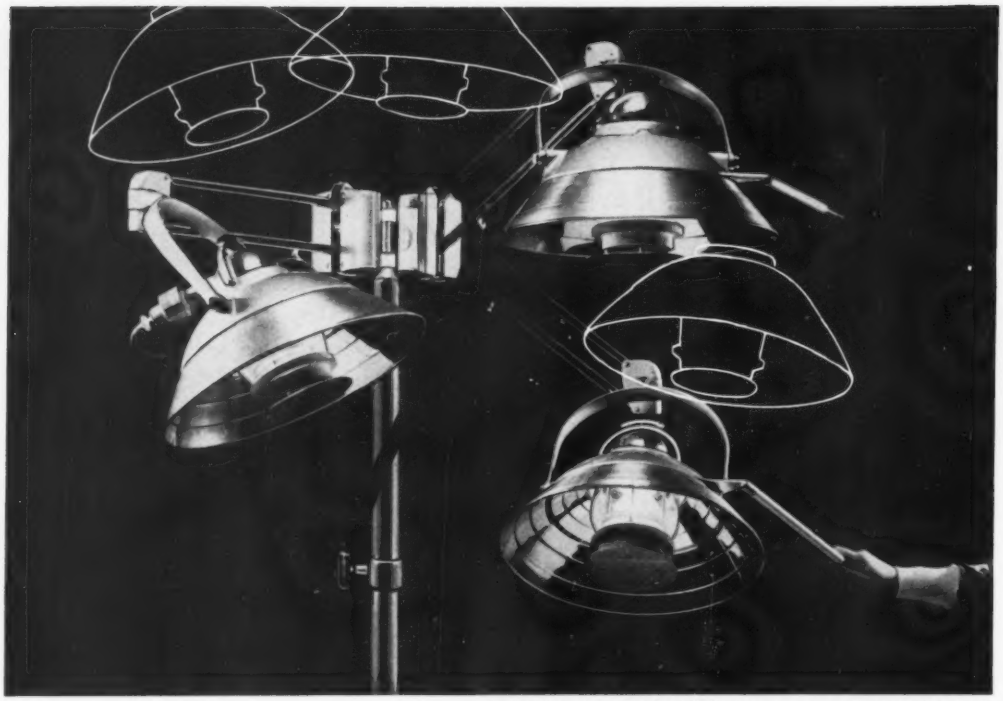
Dirt cannot penetrate their tough, resilient finish. Food, oil, and grease won't harm them. And these floors are easily cleaned—they withstand strong cleaning compounds, soap and water, acid and alkali solutions—yet require no waxing to keep their lustre.

Tile or continuous flooring of VINYLITE Resins is always flexible, conforming to uneven wood floors and normal floor play without cracking. It can be laid on concrete in direct contact with the ground.

And, besides saving money on wear and maintenance, floors like these are adding color and new life to the decor of leading hospitals, restaurants, shops and showrooms throughout the country. They have the properties of the VINYLITE Resins and Plastics that are so useful throughout defense and basic industry. Get them for your particular job. For a list of suppliers, write Dept. NQ-85.

Vinylite
BRAND
RESINS
TRADE MARK

BAKELITE COMPANY, *A Division of Union Carbide and Carbon Corporation* UCC 30 East 42nd Street, New York 17, N. Y.



The Castle Explosion-Proof Safelight shown in a composite action photograph

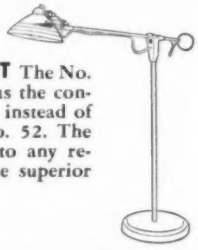
Why operating teams like this flexible, explosion-proof *Castle* Safelight

THE SURGEON BECAUSE: He gets the exceptional quality of light he expects and wants, just where he wants it, and *when* he wants it—*even when the nurse is not experienced.*

THE ASSISTANT BECAUSE: The novel optical system reduces shadow effects and *his helping* hands do not interfere with the surgeon's light.

THE SURGICAL NURSE BECAUSE: Quickly, as easily as pointing her finger, she can point the light just where the surgeon wants it. With universal focus the light is correct the instant she directs it.

THE ANAESTHETIST BECAUSE: He gets proper, color-corrected light for quick *perception of cyanosis.* He also knows that the Castle Safelight is explosion-proof and approved by the Underwriters' Laboratory for use in Class 1, Group C, Hazardous Locations.

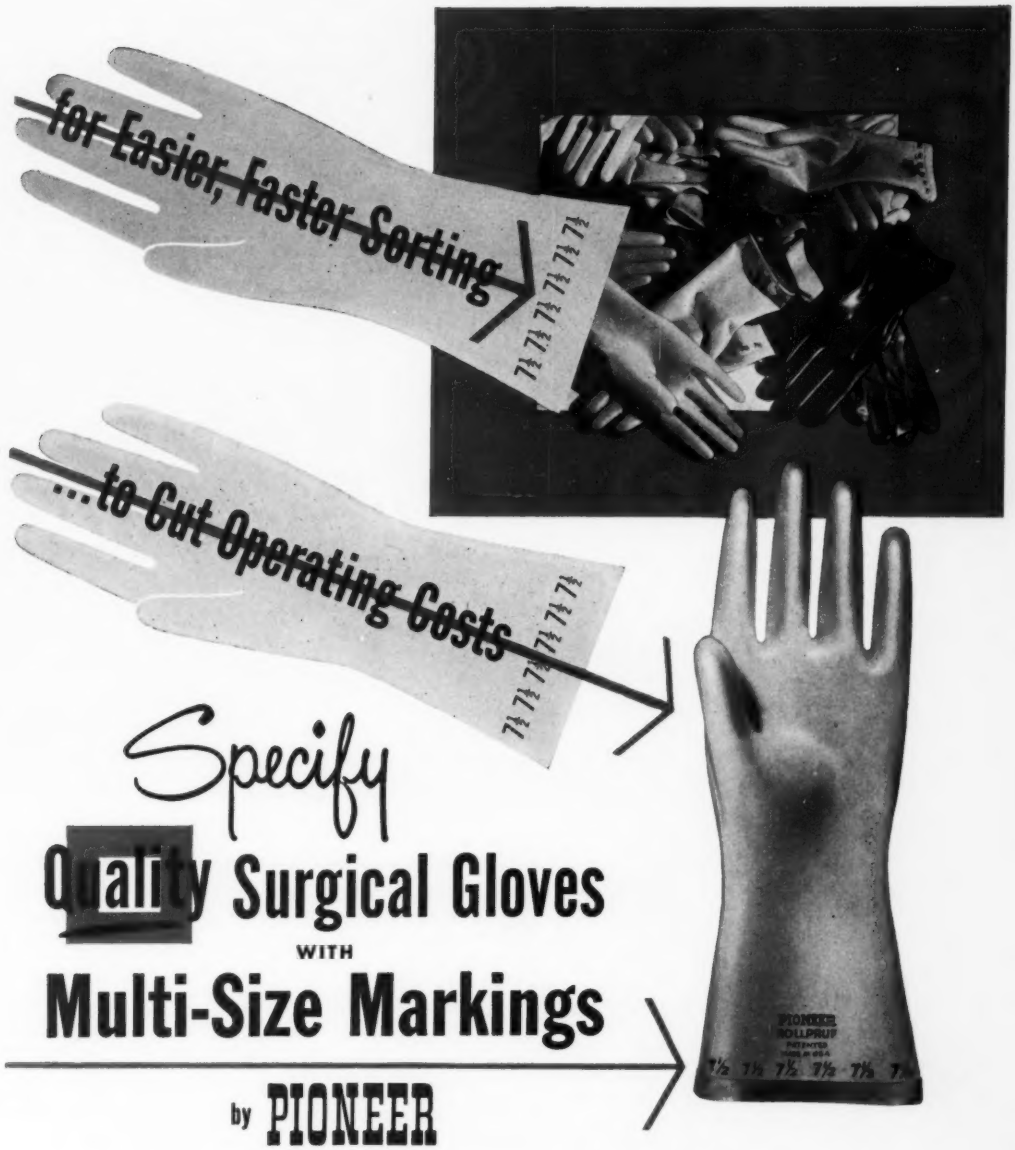


CASTLE NO. 51 SAFELIGHT The No. 51 explosion-proof Safelight has the conventional counter-balanced arm instead of the pantograph arm on the No. 52. The lamphead raises, lowers, tilts to any required angle. It gives the same superior quality illumination.

EMERGENCY POWER UNITS AVAILABLE

Consult your dealer. For catalog write Wilmot Castle Co., 1271 University Ave., Rochester 7, N. Y

Castle **LIGHTS AND STERILIZERS**



Specify Quality Surgical Gloves WITH Multi-Size Markings

by **PIONEER**

7½ 7½ 7½ 7½ 7½ 7½ – size is printed in a row across the cuff – easily visible in any pile. Speeds up sorting, reduces labor costs. Of highest grade virgin latex, doctors and nurses everywhere prefer their greater sensitivity. Beadless flat-banded Rollprufs won't roll down during surgery. Longer-wearing, they cost less in the long run! Order today from your wholesaler or write us.

Rollpruf
TM TPRCo.

the PIONEER Rubber Company
750 TIFFIN ROAD • WILLARD, OHIO

Equipment courtesy of
A. S. Aloe Company
General Offices—St. Louis, Mo.

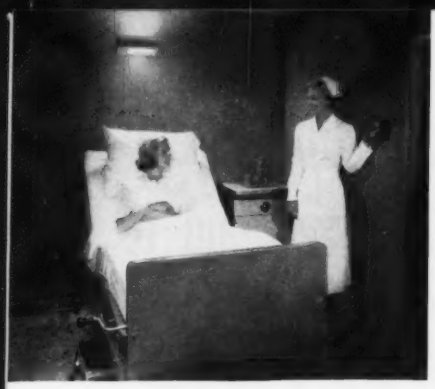
Good hospital lighting *can* mean many things to many people. To the patient, good local lighting means a measure of comfort and convenience . . . and the reassurance that inevitably results from the knowledge that he is in the hands of a well-managed, up-to-the-minute organization.

To the hospital visitor . . . especially to the patients' loved ones . . . good lighting means a lasting impression of 20th Century efficiency and the highest standards of cleanliness . . . and the reassurance inherent in these benefits.

To the staff . . . professional and non-professional alike . . . good general lighting means a more pleasant place to work and freedom from tension and nervous fatigue due to eyestrain.

And to the hospital administrator, good lighting means a staff that works better, more efficiently . . . with fewer mistakes and less loss of time, effort, and money due to employee turnover.

In short, good hospital lighting means better "human relations". . . greater public acceptance. And even when hospital beds are at a premium, a favorable public attitude is important to *every* hospital.



Soft, indirect general purpose lighting is controlled by nurse from a switch panel inside Patient Room door. Day-Brite Bed Lamps are designed for maximum patient comfort and convenience . . . are built for years of trouble-free performance.

Recessed Day-Brite Nite Lights are also controlled from a switch panel inside the Patient Room door, provide up to 100 watts of illumination—ample for normal patient needs. They're ideal for hospital corridors and wards, too.

More and more of the nation's hospitals are going Day-Brite throughout. Because Day-Brite provides the quantity and quality of illumination that creates better working conditions for the staff and a more pleasant atmosphere for patients.

by Good Hospital Lighting ?

GOOD HOSPITAL LIGHTING starts with the patient's room . . . "home" to the person who must live there for days or weeks or months. Good lighting takes some of the "sick" out of the sick room . . . helps create a more comfortable, more relaxing atmosphere.

For example, in a typical Day-Brite lighted private or semi-private room (like the one pictured on the opposite page), there are no harsh brightness contrasts common with ordinary ceiling fixtures. Patients get both direct light for reading and soft, indirect illumination for general use from a single glare-proof bed lamp that has been specifically designed for his comfort and convenience.

The 3-lamp Day-Brite Bed Light is mounted 7-feet up on the wall at the rear of the patient's bed . . . out of the patient's reach. A pull switch enables him to turn on the 60-watt reading lamp at will. End lamps for indirect lighting are controlled by the nurse at the door. A handy electrical outlet completes this Day-Brite unit.

On the ward, Day-Brite Bed Lamps using a single direct-beam reading lamp are ideal supplements to general ceiling lighting.

Aside from decidedly more comfortable lighting, there are other qualities that make Day-Brite your best bet in patient room lighting. Day-Brite stainless steel construction, for example, makes these fixtures easier to keep clean . . . gives them a permanent finish that preserves a truly modern appearance for years and years.

Important, too, is the glass top-side panelling that helps diffuse light and protects against dust and dirt deposits that cut down efficiency and create maintenance problems. And Day-Brite Bed Lamps are ventilated at top and bottom for cooler, safer operation. All Day-Brite fixtures are Underwriter Approved, of course.

In the patient's lavatory, Day-Brite Lavatory Units using one 50 or 60 watt lamp for direct/indirect illumination are also of stainless steel construction and feature the glass top, convenience receptacle, and top and bottom ventilation.

For after visiting hours, Day-Brite louvered hinged face Nite Lights—with wattages up to 100—provide ample illumination for normal sick room needs. These recessed units are usually placed 24 inches from the floor to right or left of the door. Staggered at intervals of 18 feet, Day-Brite Nite Lights are ideal for hospital corridors, too.

Patient Room lighting by Day-Brite is amazingly simple and inexpensive. It provides really comfortable illumination for the patient, and its remote control features for indirect and night lighting save time and trouble for busy hospital nurses.

There's a Day-Brite fixture for practically every hospital lighting need—for lobbies and admitting rooms, for corridors, offices and clinics; for central supply rooms and pharmacies and hospital laboratories; for every service area. Day-Brite has long been an outstanding leader in the manufacturing of the finest industrial, commercial, and hospital lighting fixtures. Why not let Day-Brite's experienced engineers help solve your hospital lighting problem?

For complete information, WRITE: Day-Brite Lighting, Inc., 5455 Bulwer Ave., St. Louis 7, Mo. In Canada: Amalgamated Electric Corp., Ltd., Toronto 6, Ontario.

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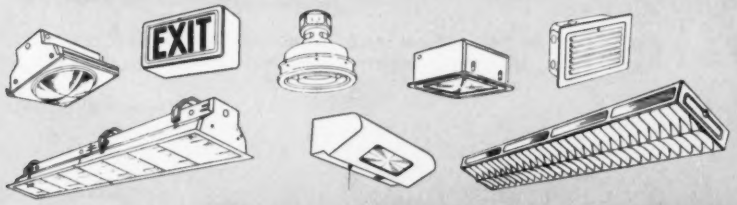

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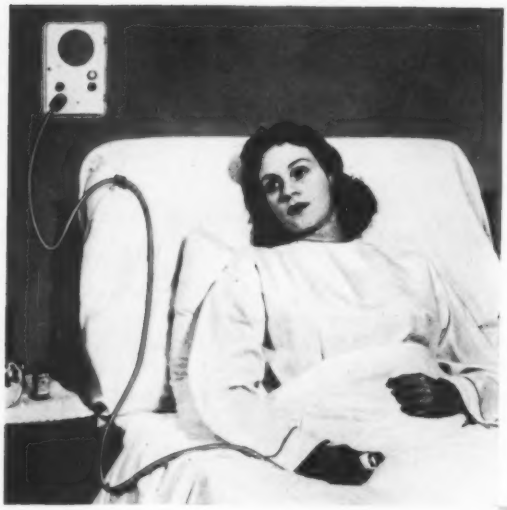

"Like having a private nurse" says the patient!

"Like having one private patient" says the nurse!

Yes, they're both happier—and with good reason. The patient has the psychological advantage of knowing that her smallest need will get immediate attention. She knows she will be heard when she wants to be heard even if she whispers, no matter in what direction she faces. So long as she can move her thumb and make a sound, she's sure of attention. Knowing this, she is less demanding, more relaxed.

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Nurses' control available in two styles: With speaker-microphone and telephone handset for auxiliary use . . . or with telephone handset only.

In addition to Vokalcall Systems for hospitals Auth also produces standard visual nurses' call systems, doctors' paging and in-and-out systems, clock systems and operating room timers, intercom telephone and fire alarm systems, and night lights.

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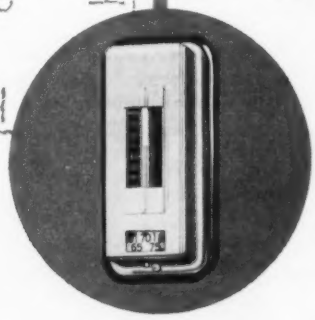

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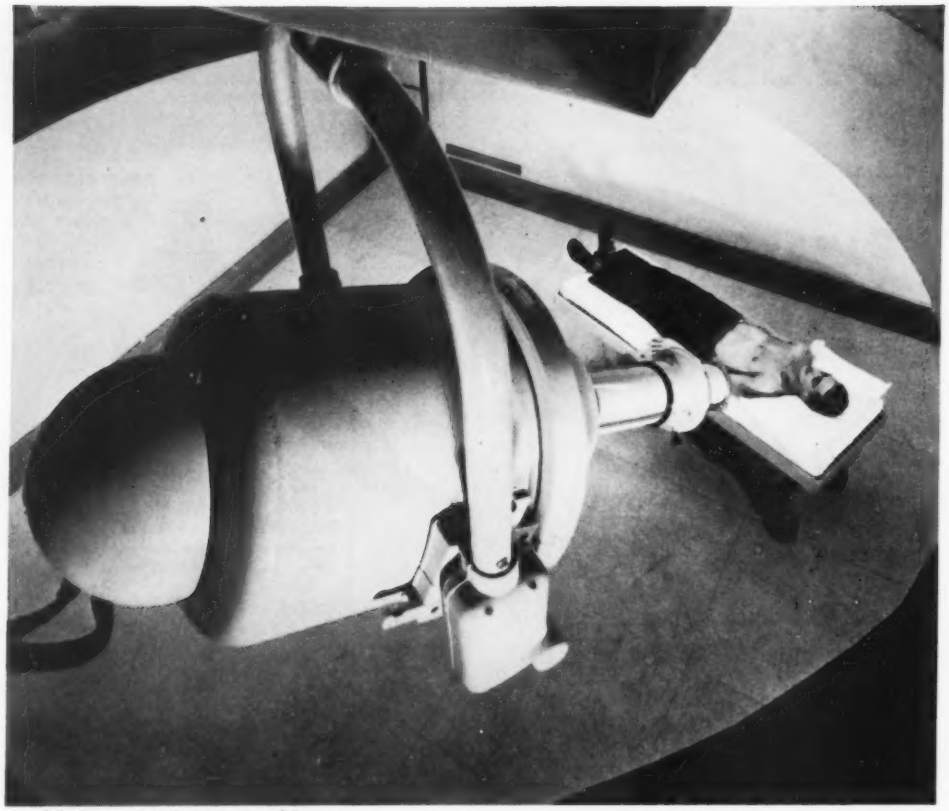

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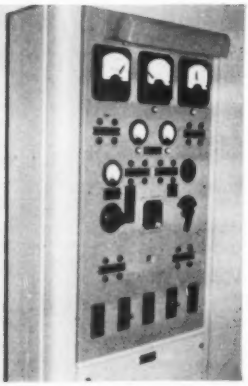

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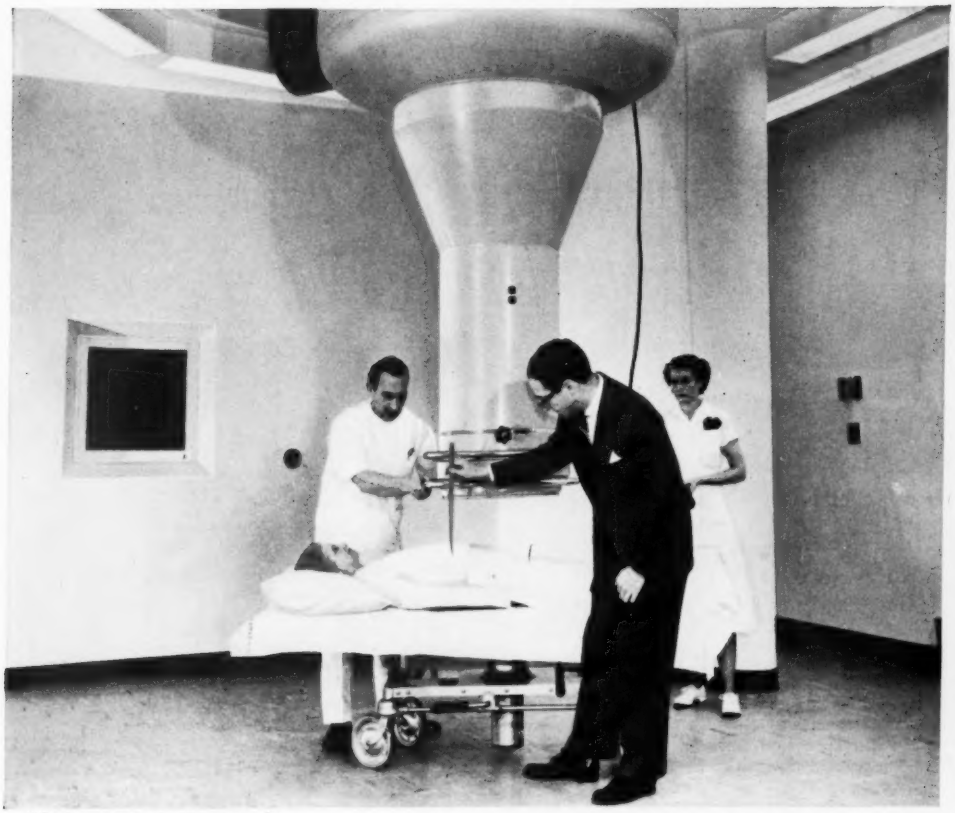

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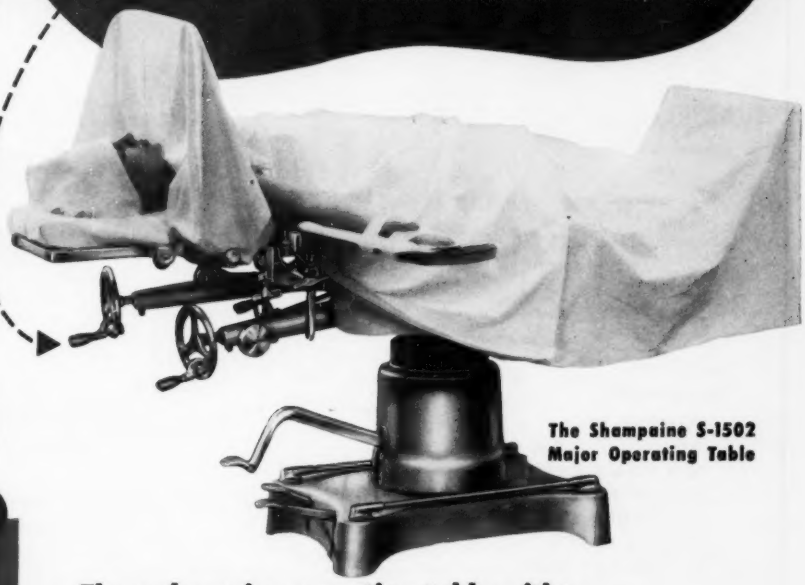

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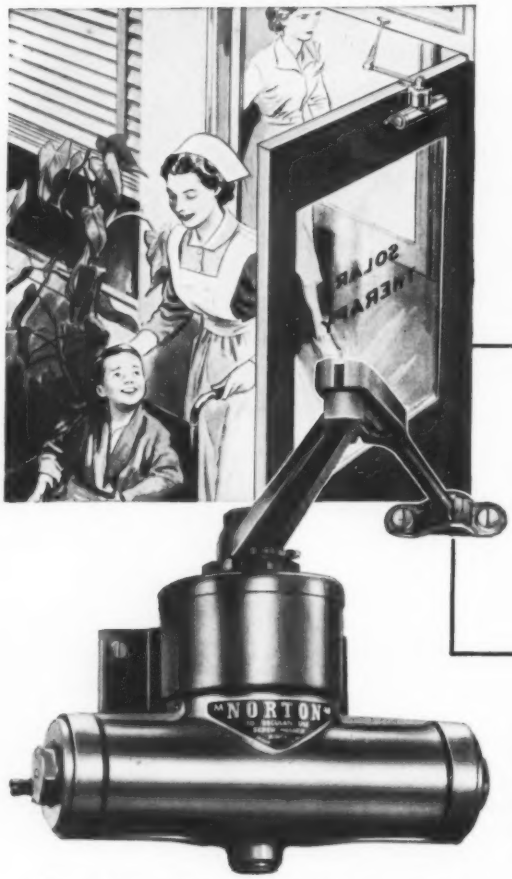

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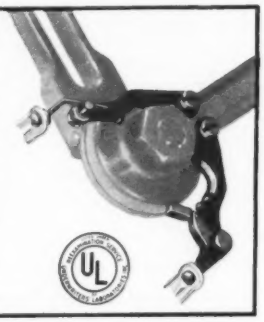

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Small Hospital Questions

Communication System

Question: We are considering the installation of a two-way call system between the patients' rooms and nurse's station in a new wing of our hospital. Can you tell us what the experience of hospitals having such installations has been? We are told it is economical, inasmuch as it conserves the time of nurses answering lights. On the other hand, it represents a fairly substantial investment for a hospital of our size, and we should like information based on actual experience, if it is available.—E.M., Calif.

ANSWER: Many nursing directors and head nurses in hospitals having two-way communication systems on nursing units have reported that the system results in nursing economies and improved patient care. Many unnecessary trips are saved when the nurse and patient can communicate directly with one another from bed and nurses' station. "The communication system is especially valuable," a head nurse at one such hospital said recently. "I can sit at my desk in the nurse's station and communicate directly with patients throughout the unit; as a matter of fact, by simply flipping a switch, I can even listen to the breathing of some patients who are seriously ill and keep informed of their condition without making frequent visits to the bedside."

One objection to the system has been, however, that it encourages the patient to make frequent demands on nursing service which are not absolutely necessary. "The patient may hesitate to turn on his light when he knows it means an extra trip for the nurse on duty," one nurse reported, "yet he will not hesitate to communicate over the speaker system."

Most hospital and nursing authorities believe, however, that abuses are infrequent and that no patient should refrain from asking for service when he thinks he needs it, even though the request is not absolutely essential. Authorities agree also that head nurses and general duty nurses must be thoroughly indoctrinated in the proper use of the system before it is installed in order to take advantage of the economies it offers. Nurses who are not educated in the use of two-way communication systems and prefer to make frequent visits to patients' rooms—because "they have always done it that way before"—are not likely to use such an installation intelligently and economically. The best answer to the inquiry seems to be that the installation will offer worth-while economies and improved service if it is installed and operated under wise administrative and nursing management.

"Amateur Doctors"

Question: In our hospital in a small community a part, at least, of the "nursing shortage" problem develops from the fact that the doctors are so busy nurses are required to undertake many responsibilities on their own that were formerly discharged only under direct medical supervision. I refer to such things as giving intravenous solutions, removing sutures, changing dressings, and other procedures essentially medical in character but necessarily performed by nurses today because our doctors seem to be too busy to handle this type of routine work. In fact, some of our nurses say that the way things are today they are expected to be "amateur doctors."

For experienced, well trained nurses without too much to do it is possible that such procedures might be carried out properly without direct medical supervision. Under today's circumstances, however, when we are shorthanded and have necessarily had to employ some nurses on general duty who are not experienced and to "piece out" our staff with auxiliary personnel, it seems to us there is a hazard involved in the situation. Nevertheless, all our efforts to improve these practices by insisting on closer medical supervision seem to fall short of success.

Is this situation common, or is it peculiar to our area? Do you have suggestions for obtaining staff cooperation to overcome the conditions described here?—J.M.L., Ohio.

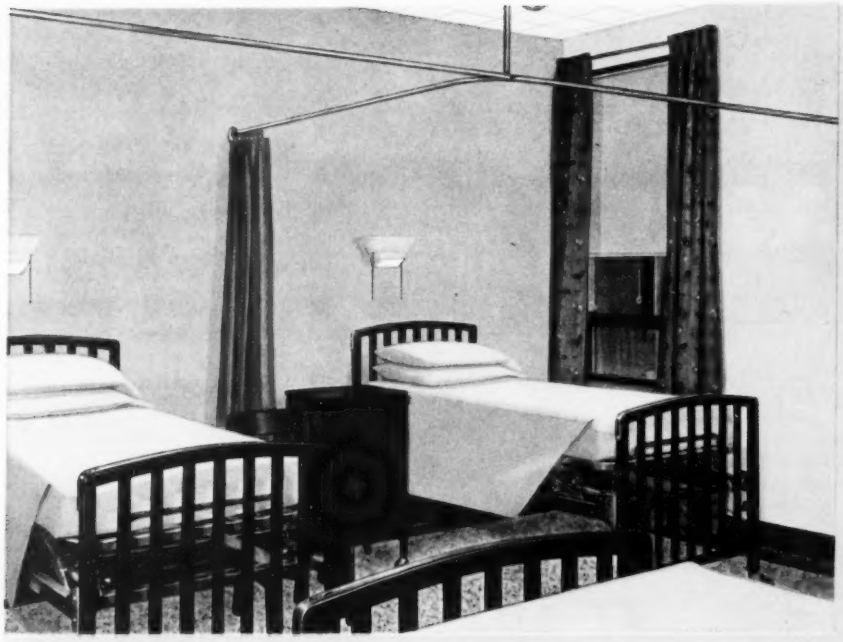
ANSWER: Many administrators and nursing directors in smaller hospitals, in small communities and rural areas, have described much the same situation that is presented here. Some hospital and nursing people are alarmed at what they consider to be an "unloading process" by which the nurse and hospital are made to assume work that they think should be done by the doctor. Others see no particular cause for alarm, so long as these procedures are carried out by trained, efficient nursing personnel, which has been adequately prepared for these responsibilities by the medical staff. This group feels there is a natural and inevitable transfer of function, as medical science and medical practice become constantly more complex, from the doctor to the nurse and other trained assistants. It is suggested that care of patients will suffer only when procedures, either medical or nursing, are carried out by people who are not properly trained or who do not have time to perform their duties efficiently. Our only suggestion in this situation would be for frank discussion of the problem with appropriate medical staff authorities, looking toward the development of supervisory and training programs aimed at making certain no nurse is required to carry out procedures for which she is not trained and does not have adequate time. These are proper subjects for continuing staff-administration discussion and liaison effort.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala., William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Handling Insurance Items

Question: How do you account for any expired insurance premiums as a matter of office routine or practice?—F.H., Ill.

ANSWER: Spreading insurance premiums, dividends from mutual insurance, refunds because of cancellation, and so forth, into monthly columns representing the life of the policies is both difficult and laborious. It is easier to estimate the annual cost of insurance and to charge one-twelfth of such cost to insurance each month, then at the end of the fiscal year analyze all charges and credits to prepaid insurance and leave in that account the portion of the premiums that extend beyond the fiscal year. All dividends and refunds are credited to the fiscal year. When the total of unexpired premiums is determined an adjustment is made to the balance in the account, *i.e.* insurance is charged or credited with the adjustment. We find the adjustment is seldom large and this method saves a lot of time during the year.—PAUL B. MURPHY, *business manager, Clarkson College of Technology.*



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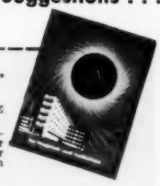

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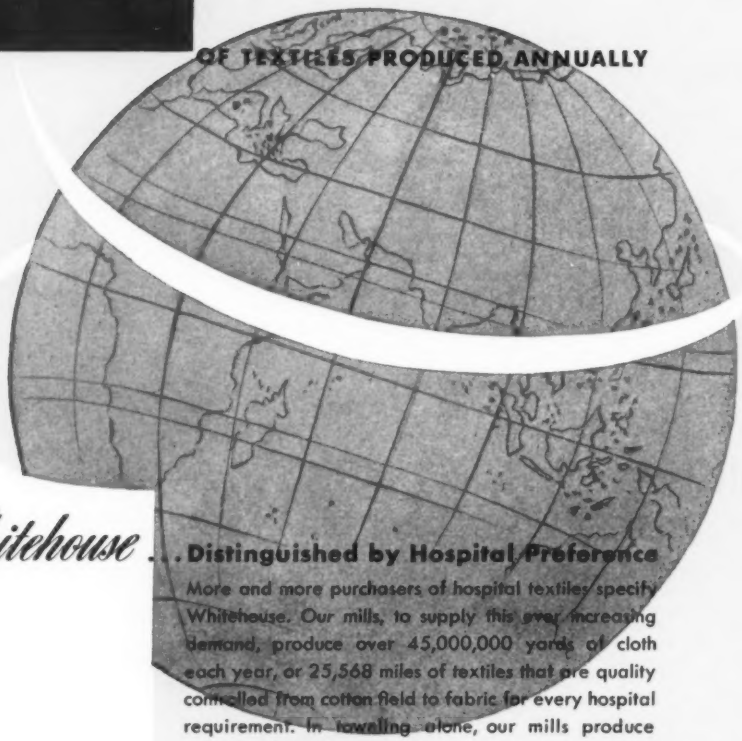

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wire from Washington

HOSPITAL PARLEY

Once again a group of authorities, government and private, have seated themselves around a big table to argue out hospital problems—from how best to shave a dollar to keeping the medical staff satisfied. This particular group was a panel selected by the President's Commission on the Health Needs of the Nation. Its deliberations were secret. A summary of its conclusions will be submitted to the full commission for inclusion in the commission's final report, due at the White House at the end of this year.

The day-long meeting looked into a variety of subjects. After presentation of papers, panel members questioned each other, then reached conclusions. Problems taken up included:

1. **Requirements** for planning and construction and how to meet them, particularly financial requirements.
2. **What hospital services** should be provided, and how to handle outpatient departments, group practice, ambulatory service, home care service, and rehabilitation service.
3. **Relationships** between hospitals and their medical staffs, including appointments and finances.
4. **Relationships** between the hospital and (a) the university, (b) other community resources, including nursing homes, physicians, public health departments, and (c) regional planning agencies.
5. **Efficient utilization** of diagnostic facilities and personnel, including visiting or courtesy staff as well as house staff.
6. **Licensure** and hospital accreditation.
7. **Impact of prepayment** on hospital occupancy and type of accommodations and the teaching of medical students.

Underlying theme was not what should a hospital do but what can it afford to do.

Dr. Dean Clark, administrator of Massachusetts General Hospital and a commission member, presided. **Dr. A. J. J. Rourke,** president of American Hospital Association, was keynoter. Participants included **Dr. John W. Cronin,** chief of the Division of Hospital Facilities, U.S. Public Health Service; **Dr. Edwin L. Crosby,** director, the Johns Hopkins Hospital, Baltimore; **Dr. Basil MacLean,** director, Strong Memorial Hospital and professor of hospital administration, University of Rochester, Rochester, N.Y.; **Dr. Jack Masur,** assistant surgeon general of Public Health Service and chief of the Bureau of Medical Services; **Dr. G. Otis Whitecotton,** medical director, Alameda County Institutions, Oakland, Calif.; **Harry Becker,** associate director, Commission on Financing Hospital Care, Chicago; **J. Hamilton Cheston,** president of the Philadelphia Savings Fund Society and trustee of the Women's Medical College and Hospital, Philadelphia; **Graham L. Davis,** director of the Commission on Financing Hospital Care, Chicago; the **Rev. Donald A. McGowan,** director of the Bureau of Health and Hospitals, National Catholic Welfare Conference, Washington, D.C.; **Jacque B. Norman,** hospital consultant, Greenville, S.C.; **O. G. Pratt,** executive director, Rhode Island Hospital, Providence, R.I.

FISCAL FLOP

Community Facilities Act enacted by the last Congress, toward which so many hospitals had looked longingly for financial assistance, could be described accurately as a total flop.

The basic law, passed more than a year ago, was intended to provide funds for construction (and, if necessary, operation) of hospitals or clinics in crowded defense areas, as well as for such other community facilities as police and fire protection, schools and water and sewage treatment plants. However, Congress last year said it didn't think hospitals needed help at the time and refused them appropriations.

However, if hospitals are needed in officially-designated defense areas, application should be made; the more applications, the more evidence to present to a doubting Congress in January. NOTE: Submit applications through Federal Security Agency regional offices and include evidence that (a) help had been asked and refused through the Hill-Burton program, and (b) the local responsible authorities cannot or will not undertake the task of raising funds or operating the hospital.

CONSTRUCTION OUTLOOK

For more than a month, hospital construction has been suffering from effects of the steel strike, which in its first six weeks cost the country all the production that would have been added by 1952 plant expansion.

Government officials still are hopeful that most projects already under way will be allowed to continue, with shortages compensated by restricting new starts. To accomplish this, all new projects scheduled to begin in the last six months of the year were reclassified in three categories, with those directly tied to the military effort given top priority. To minimize inconvenience, jobs scheduled for third quarter starts in most cases will be allowed to proceed. But the plan is to impose a virtual freeze on fourth quarter starts.

Because of the strike, announcement of fourth quarter steel allocations was held up indefinitely. However, there was virtually no pinch in copper and aluminum, partly because steel shortages held up building projects which would have used large amounts of these two metals. For hospital construction and maintenance, the Division of Civilian Health Requirements (Public Health Service) was allowed 3,875,000 pounds of copper for the fourth quarter, and 390,000 pounds of aluminum. These represented substantial increases over the third quarter, particularly in aluminum. Third quarter allocations for hospitals were 3,325,000 pounds of copper and 230,000 pounds of aluminum.

For planning purposes, the hospital construction industry is allowed to proceed on the basis of an advance fourth quarter steel allocation representing 80 per cent of the third quarter total. A sharp curtailment is anticipated, however, after the impact of the steel work stoppage is measured.

Despite unhappy prospects for steel, the Division of Civilian Health Requirements has this advice: "Sponsors of health facility construction projects should continue to file their applications for new fourth quarter starts, but should make every effort, through conservation methods, to keep their steel requirements to a minimum."

Control Notes: If a builder has enough carbon steel on hand for a project, he may start it and move ahead, regardless of regulations and quotas; this is to hold down unemployment wherever possible. . . . Also born of the strike is a revised regulation allowing self-certification for 750 pounds of copper per quarter per project, instead of 200 pounds. Self-certification for 1000 pounds of aluminum also is permitted; previously no aluminum could be obtained on self-certification. . . . If you have steel on order, and covered by a regular allocation "ticket," your priority will not be affected by delays. An N.P.A. directive states that "producers of steel and products containing steel [are required to] reschedule their operations in such a manner as to assure delivery on all orders covered by N.P.A. directives in the sequence of their original specified delivery date."

CONSUMPTION DATA

Half of the nation's hospitals have now completed and returned their questionnaires in the survey of civilian hospital needs being conducted by Public Health Service and American Hospital Association. It is designed to help in allocating vital equipment and supplies and to justify production expansion where necessary.

Wesley E. Gilbertson, chief of Public Health Service's Division of Civilian Health Requirements, urged hospital administrators who have not returned the form to (a) verify that items reported are exactly the same as those requested on the form, (b) make sure that each box in the heading on the form contains an entry, (c) convert information respecting quantities to the units of measure requested, and (d) carefully review the completed questionnaire before mailing.

CIVIL DEFENSE

Unless Congress is willing to grant more money in a deficiency appropriation next year, the Federal Civil Defense Administration will be lumbering along at a slow pace during the next 12 months.

For the last fiscal year, ending July 1, 1952, F.C.D.A. was allowed about $100,000,000, of which 85 per cent was used for purchase of medical supplies. With the whole civil defense operation rapidly filling out at all levels, the federal officials asked Congress for $600,000,000. The figure might have been pretty high; at least it is debatable whether medical supply and equipment houses could turn out the additional production over one year's time. Congress decided the $600,000,000 figure was completely unrealistic. Instead it gave F.C.D.A. $43,000,000 for everything. Left with F.C.D.A. officials was the decision on how to divide up the funds among medical and nonmedical accounts.

Congressional committees made it plain they were terrifically unimpressed with the way states and cities were sitting back and waiting for the federal government to underwrite every civil defense dollar. Unless the states and cities use up the $15,000,000 matching money, and in a hurry, the next Congress can be expected to be just as hard-boiled.

CLOSE CALL

Republicans, Democrats and American Medical Association—all of them—had a close, close call on the social security bill, which will give more money to 8,000,000 beneficiaries, starting October 1.

A.M.A. stalled the bill once in the House. There was some question at that time whether the Democrats would bring it out again or let it die—and blame the Republicans and the doctors, who had complained that one section of the bill offered a threat of socialized medicine. But—after a delay dangerously late in the session—the administration decided not to take a chance. The House took another vote and passed the bill. The disputed section was completely deleted in the Senate. Compromise was not reached until a few hours before the hour set for adjournment. Under the compromise the disputed section was left in the bill, but in a form probably not objectionable to doctors, and the legislation was so drafted that the section cannot become operative until after both houses have had time for hearings, which were dispensed with in the closing rush.

Result is that both Republicans and Democrats can take credit for giving old persons and dependent children larger monthly payments—and the American Medical Association cannot be blamed for blocking a worthy bill. Actually, the association at no time had opposed the bill itself—only the one section.

V.A. SURVEY

A touch of mystery is being added to the Booz, Allen and Hamilton management study of Veterans Administration, making the document even more interesting than it would be anyway. A year and a half ago, V.A. engaged the firm to make a complete analysis of the agency's operations and prepare a set of recommendations. At Congressional hearings, it was brought out that the cost would be about $600,000. This didn't sound too much like economy to the House committee, which instructed V.A. in the future to check first with Congress before spending any like amount of money for surveys.

The small staff of investigators, as well as V.A. officials concerned, have kept tight-lipped on results of the survey. It has been completed for about two months now and V.A. Administrator Carl R. Gray Jr. is studying it. He will decide what parts to release and when to release them. Even to the House committee, Mr. Gray would only say that it may be September 1 before the public is let in on the facts.

Under the circumstances, it is natural that rumors would start floating around Washington. One is to the effect that the report is so critical of V.A. and calls for so many radical changes that Mr. Gray can't decide what to do with it. Another suggestion is that Mr. Gray and his top advisers are quietly putting into operation some of the recommended reforms, so that the report, when released, may be accompanied by an impressive list of "changes already effected."

Two things are pretty certain: The report will have a lot to say about V.A.'s medical department and hospitals, and if the complete document is not released by V.A., Congress can be depended upon to order it released.

LOOKING AROUND

Cold Dope

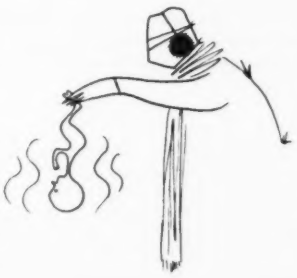
LIKE a squirrel on a treadmill, progress sometimes has to run as fast as it can to stay in the same place. A few weeks ago, the administrator of a beautiful new hospital in the South related, the chief obstetrician requested the installation of an expensive electric blanket warmer in the delivery room suite. The delivery rooms were air conditioned, it developed, and the cold air was a hazard to newborn infants.

Broad View

DURING the last two or three years it has become popular for hospital people to point out to one another that interpersonal and intergroup relations in the hospital are among the most complicated and difficult that we have in our society. From time to time, experts from industry and the universities have been called in to examine the problem and make a diagnosis.

From these and other studies, it seems plain that there are two principal circumstances that set the hospital apart from other organizations. These are, first, the dual authority under which management employs the people but the doctors, who are not responsible to management, tell them what to do, and, second, the hospital caste system, whose rigid social distinctions would make an Italian court of the Sixteenth Century look like a boilermakers' union on Brotherhood Day.

In a democratic society which prides itself on the fluidity of its social classes, the hospital permits an average employe less hope of improved social standing than he has been taught to expect of life generally. Unlike employes of industry who learn their skills on the job and can often move along as rapidly and as far as their energies and abilities will take them, hospital employes are frequently frozen in layers; the employe who advances to the top of his own layer has gone about as far as he can go; the hospital population consists for the most part of nurses who can never be doctors, aides who can never be nurses, maids who can never be aides, and little groups of technicians who are remote from everybody, including one another. "Such a social structure has important effects on the nature and flow of communication through the system," says one examining physician —in this case Dr. William Caudill of Yale University.



These are serious, deep-rooted problems, never to be solved by cheery front-office pronouncements in the "happy family" genre, nor by occasional "think out loud" group meetings in which everybody is under embarrassed compulsion to use first names. In his search for the means to cope with problems arising from hospital castes, the administrator may find as much help in the past as in today's brightly labeled new technics. It may comfort him, for example, to know that these same problems have been recognized for at least 100 years. "Every professional man rightly has a zeal for his own profession," Cardinal Newman said in his lecture to the medical students at the Catholic University of Dublin in 1852, "and he would not do his duty towards it without that zeal. And that zeal soon becomes exclusive. . . . A zealous professional man soon comes to think that his profession is all in all, and that the world would not go on without it."

The administrator is thus confronted with the task of developing effective communication and cooperation among

several groups of professional people afflicted with this exclusiveness which makes them, again in Cardinal Newman's words, "think their own line the only line in the whole world worth pursuing, and feel a sort of contempt for such studies as move upon any other line." It may well be that the task is impossible. Certainly the answer is not to be found solely in recourse to a new professionalism of management which already shows symptoms of a burgeoning exclusiveness of its own.

To the blind exclusiveness of the professional person, Cardinal Newman opposed another type of mind—the master mind, as he called it, "gifted with a broad philosophical view of things, a creative power and a versatility capable of accommodating itself to various provinces of thought." Unquestionably, the hospital administrator today needs a broad, philosophical view of things, and he needs the ability to accommodate quickly to various provinces of thought. These are not gifts to be had for the asking, nor are they to be found in textbooks. It seems reasonable to expect that the broad philosophical view should be sought instead in philosophy. Cardinal Newman is not a bad place to begin.

Chip

ONE of the distinguishing characteristics of American society is its passionate interest in occupation. A question that would be an unthinkable vulgarity in other cultures, "What do you do for a living?" is asked and answered here as a matter of course; commonly, we learn all about a stranger's livelihood before we know his name or place of origin.

Inevitably, some of this preoccupation with vocation rubs off on our youngsters; the average American child emits odd facts about his father's business like a chamber of commerce bulletin. Our impression of this phenomenon was confirmed not long ago when we were a dinner guest in the home of a hospital administrator, where we offered the standard questions about school and the Lone Ranger to a boy of seven or eight, and got back the standard solemn, silent inspection.

Outwardly untouched by his father's calling, the child appeared to us to be indistinguishable from the progeny of law, insurance or wholesale soft goods, a deception which lasted midway through the roast lamb. At this point, Junior took advantage of a lull in the conversation to make his first, and only, pronouncement of the evening.

"P-h-t-h-i-s-i-s," he declared soberly, "spells *ty*-sis. This is an advanced tuberculous condition of the lungs."

Underground

IN OUR time, the odds have changed in man's age-old struggle against his environment. Long a formidable opponent, the elements are no longer a match for the awesome forces of science. What electronics won't accomplish, atomic energy will—if not today, then no later than day after tomorrow.

Like a crooked politician who resorts to vote stealing when campaign oratory fails, however, nature is turning out to be a dirty fighter. Science today must be constantly on guard against retaliatory low blows. With the new antibiotic drugs, for example, science had built up a comfortable margin against typhoid, typhus, whooping cough, Rocky Mountain spotted fever, and bacterial infections of the urinary tract. Beaten in fair contest, nature went underground and conceived a dark plot. The result was announced grimly a few weeks ago by several groups of physicians: Patients getting large doses of chloromycetin, they reported, had developed aplastic anemia, an insidious form of the disease affecting the blood-forming organs. Several patients died. Commenting on the reports, the *Journal of the American Medical Association* warned doctors to be "on the alert for reactions following therapy with this and any other antibiotic, or in fact any of the newer drugs."

Friendly Gesture

IN this day of gaudy promotions, when clothes make the man and public relations makes the institution, it is encouraging to find a hospital minding its public relations business in terms of simple thoughtfulness. The Detwiler Memorial Hospital at Wauseon, Ohio, observes special occasions by inviting patients to have a visitor in for dinner as the hospital's guest.

"This custom started about eight years ago," Mary C. Schabinger, superintendent, explained. "We had several patients who had been in the hospital for a long time, and we thought it would be nice for them to have some of their family with them on Christmas. I visited each one and asked if he would like a visitor to have Christmas dinner with him as our guest. The plan was so enthusiastically received that we have continued it ever since. We invite guests on other occasions when it seems in the interest of the patient, but on Christmas this privilege is extended to everybody, including employes who have to work that day. We thought of this as just a friendly gesture to our patients and personnel."

Static

FRIEND of ours was being shown through a new hospital the other day, stopped to reconnoiter at a nurses' station. Head nurse, no longer young and somewhat severe in manner, was proudly showing off her new gadgets. Pointed out the two-way communication system which permits her to hear what's going on in patients' rooms. "Here," she said suddenly, handing over an earphone and flipping a switch. "That's men's orthopedic."

Our man listened for a minute, then handed back the receiver and made his getaway. What he'd heard was a confused hubbub of voices, then a hoarse whisper: "Can it, Mac, the old bag may be tuned in!"

Definition

OUR favorite comment on the national conventions was made by a newscaster who was summing up his impressions of *homo politicus*. "A rattlesnake," he said, "is just an eel with a dice game in the rear."

Architectural student competition features

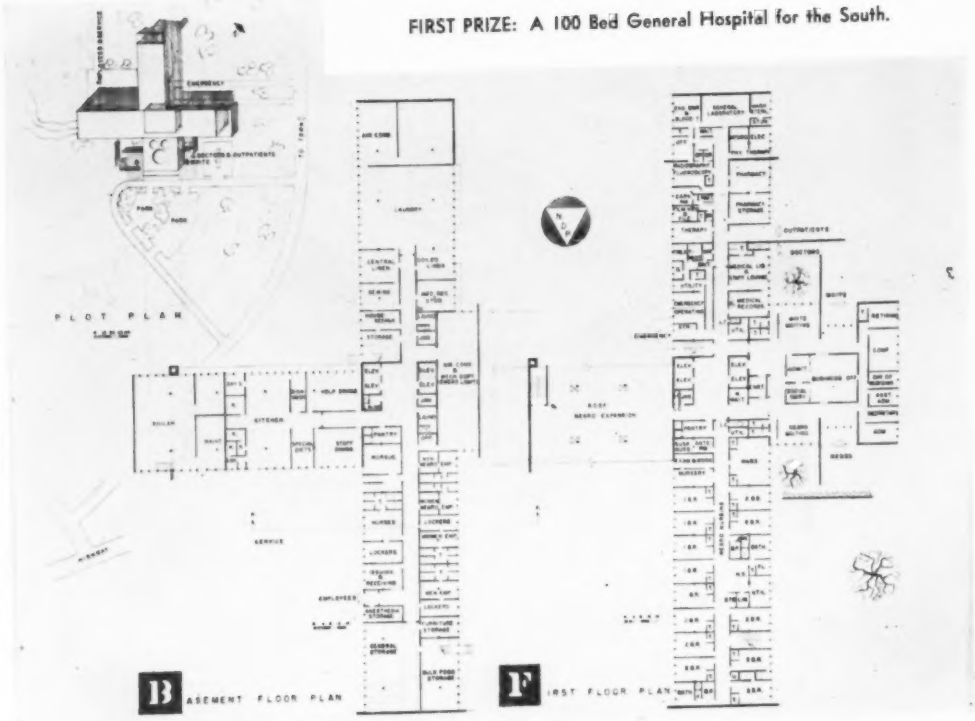
CIRCULAR HOSPITAL PLAN

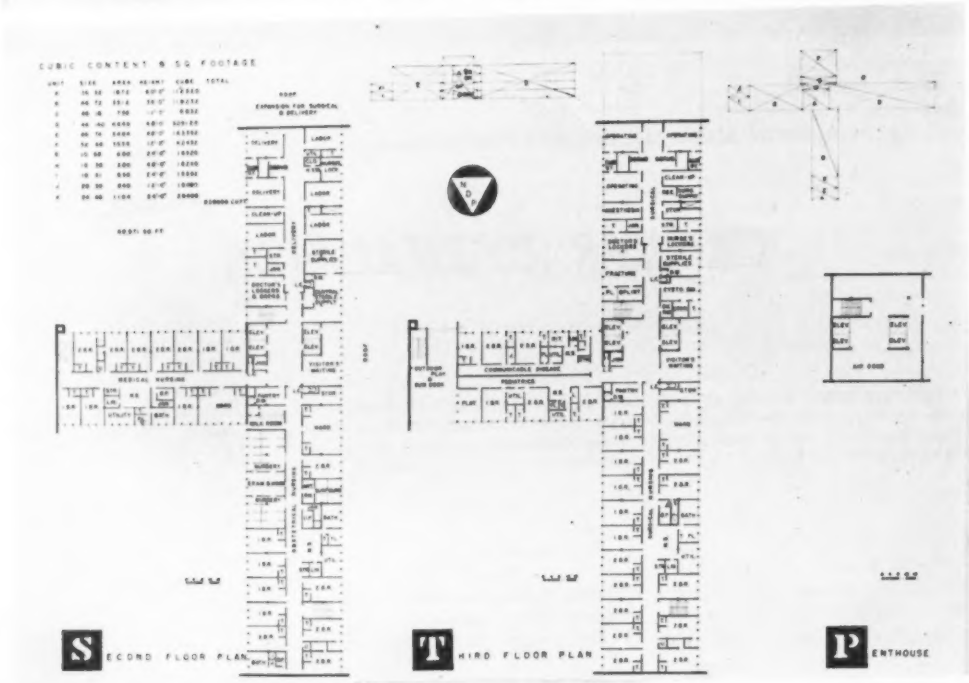
SPONSORING GROUPS: ***A.I.A.—Virginia Chapter:*** **president, Louie L. Scribner; vice president, Charles C. Justice; secretary, J. Russel Bailey; treasurer, Richard L. Meagher.** ***Carolinas-Virginias Hospitals Conference:*** **president, P. J. Mehlinger; secretary-treasurer, J. Stanley Turk. JURY: Jacque B. Norman, chairman, Herndon M. Fair, A.I.A., Roy Hudenburg, Robert Hudgens, William J. Kreps, A.I.A., Marshall Shaffer, A.I.A., F. Carter Williams, A.I.A.**

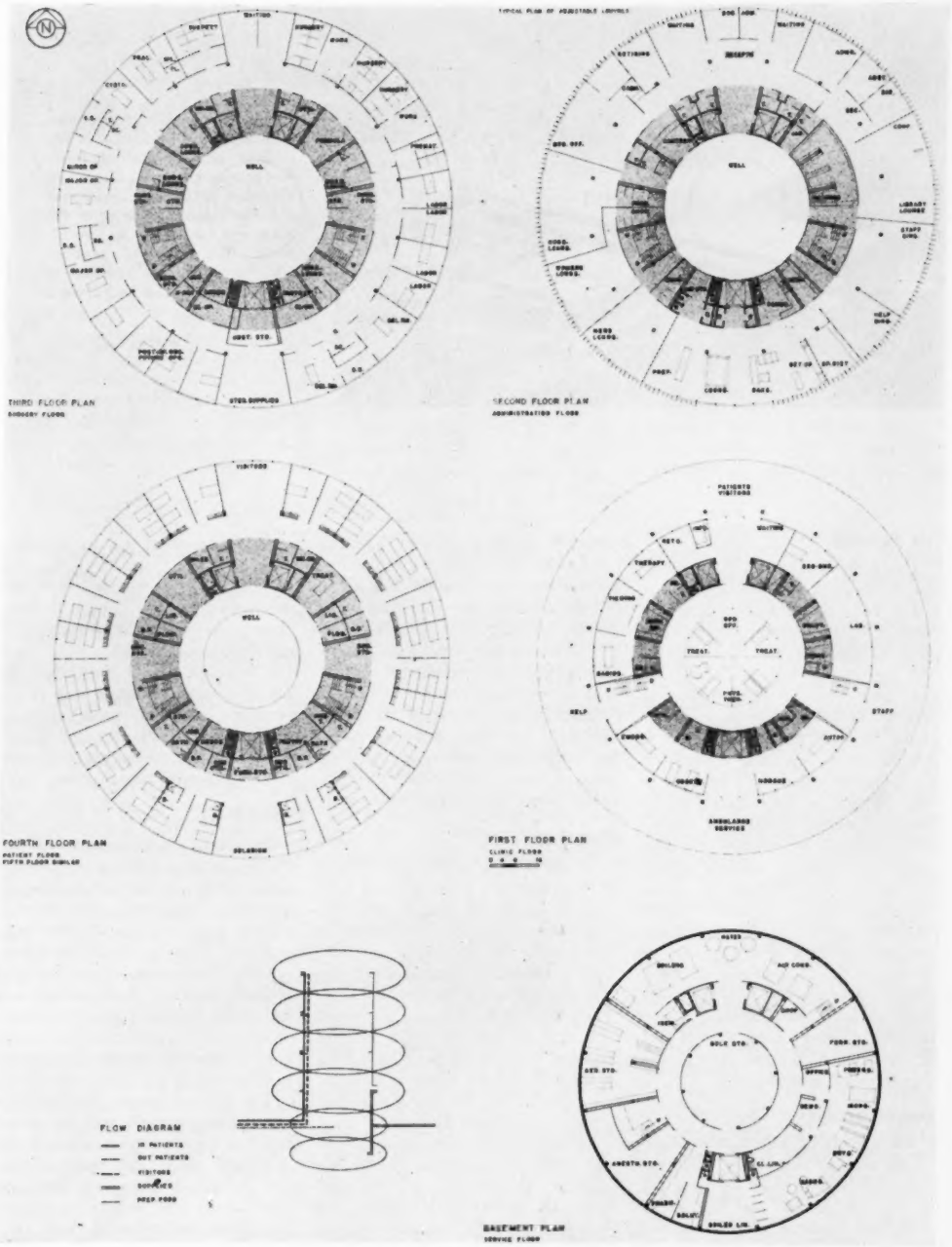
ONE of the highlights of the Carolinas-Virginias Hospital Conference held in Roanoke, Va., in May was a student architectural competition. The competition was sponsored by the conference and the Virginia chapter of the American Institute of Architects in cooperation with architectural schools in the four-state area. The jury's report on the three prize-winning entries, together with floor plans and sketches of the first-prize winner and of an unusual circular hospital which won honorable mention, is presented in these pages.

(FOR PLANS AND JURY REPORT, SEE PAGES 52, 53, 54)

FIRST PRIZE: A 100 Bed General Hospital for the South.







HONORABLE MENTION: Circular hospital selected by the jury as "one of the most unusual and imaginative schemes submitted." The flow diagram at lower left shows the traffic routes of inpatients and outpatients, visitors, supplies and food. Opposite page: Plans of the winner of the first prize.

Architect's model of the hospital that won first prize in the student architectural competition sponsored by the Carolinas-Virginias Hospital Conference and the Virginia chapter of the American Institute of Architects. The students' problem was to design a hospital of 100 beds on a 150 bed chassis.

THE PROBLEM

The problem for this competition was to design a 100 bed hospital, on a 150 bed chassis, to be located in North Carolina, South Carolina, Virginia or West Virginia. The program was written out in considerable detail, similar to the type of program that would be received by the practicing architect for the design of a hospital in a particular community. The program included the problem of race segregation by entrance to the hospital, waiting room and nursing unit, which is required in the four states in which the hospital was to be located. The hospital was to be designed with all modern features, including central piped oxygen system, air conditioning throughout, patient-to-nurse communication, emergency power system and other features of a modern hospital. A flow chart of patients' traffic, visitors' traffic, prepared food traffic, and general supply traffic was required.

REPORT OF JURY

Six schools of architecture located in the four states and the District of Columbia were invited to participate in this competition and five schools submitted a total of 34 solutions. Each school was asked to hold its own judging and submit only what the school considered the best solutions to the problem, with each school being limited to submission of a maximum of 10 solutions.

The jury recognized that this was probably the most complex problem an architectural student would encounter and consideration was given to the solutions for the complexity of the problem. The jury felt that the solutions submitted were exceptionally good and represented a great deal of study and research.

Various efforts to solve the problem were submitted, including circular hospitals, pancake or one-story structures, and one unique prefabrication based on a specific structure.

First Prize

In the opinion of the jury Walter H. Simmons submitted the best solution to the entire over-all problem. The future expansion of this solution is good as it provides ample opportunity for expanding nursing units, surgery and delivery as the need develops. The design of this building was clean-cut with a frank, straight forward solution. Though the program did not specifically call for toilets in each patient's room Mr. Simmons' plan does offer this important facility.

It was felt that four elevators were not needed in a hospital of this size and the lack of flexibility in the pediatric and communicable disease areas were the outstanding adverse criticisms of the plan.

Second Prize

The solution winning second prize, submitted by Don S. Carpenter, is a good two-story plan. This problem offered the best solution to the Negro segregation problem and its outstanding feature, in the opinion of the jury, was the handling of the obstetrical and surgical nursing units with their adjunct services of the delivery suite and the surgical suite.

It was felt by the jury that the lack of patients' toilets in each room, elevations with too much glass as oriented, and the porches being too predominant in the presentation were adverse factors to this solution.

Third Prize

The solution submitted by William Phillips Brown offered good arrangement for the service unit to the respective nursing units, *i.e.* delivery suite to maternity nursing unit, surgical suite to the surgical nursing unit, and the combination of medical and pediatric nursing. This problem was beautifully presented and considered of good design. The traffic flow in this hospital was well developed and nicely presented in the traffic flow chart.

The adverse factors affecting this solution were that the race segregation problem was not solved adequately, no outpatient department was included, and the square footage of this plan was one of the highest submitted, namely 884 square feet per bed.

The honorable mention won by Mr. Shirley was for one of the most unusual and imaginative schemes submitted. This circular solution was chosen from a total of four submitted, because this one was considered the best. The presentation was excellent.

EMPLOYE CREDIT UNIONS

reflect credit on the hospital

JOHN H. GORBY
Administrator
La Mesa Community Hospital
La Mesa, Calif.

AN EFFECTIVE method of providing hospital employes with a solution to most of their credit problems is the formation of a credit union. The benefits derived from an employe credit union are one of the goals of an enlightened personnel policy, or, as it has become popularly known, human relations.*

Credit associations, or credit unions, are composed of a group of persons who are already united by some common bond, such as a common employer or a professional society, and who are organized under a state or federal law so that collectively and by common endeavor they can attain the following purposes:

1. To teach and encourage the habit of thrift, by providing a safe and convenient medium that will attract members to save for a goal and also provide them with a fair return on these savings. The average dividend return on credit union savings is 3½ per cent annually.

2. To help members make the wisest use of consumer credit and constantly encourage them to live within their means.

3. To establish credit and lend money to members at a reasonable rate of interest for legitimate and worthwhile purposes.

THE FIRST CREDIT UNIONS

Credit unions are more than 100 years old. The first union was formed in Germany in 1848. The working people of that country were organized and taught to pool their savings, that they might furnish themselves with credit and establish a source from which to borrow, at reasonable rates of interest. The first credit union on this continent was formed among the French-Canadians in the province of Quebec in 1900. The news of the "peoples banks," as they were called, spread rapidly. Traveling priests of the Jesuit Order serving the French-Canadian residents of the New England states found that these folk were being cruelly exploited by vicious moneylenders. With the assistance of the Order, special legislation was passed by the New Hampshire legislature.

In 1909 the first credit union in the United States was formed at Manchester, N.H. And, since that time, 57 credit union leagues, corresponding in area to our state hospital associations, have been formed in the United States and Canada.

There are two types of credit unions. One is chartered under state law, operates as a corporation, and is under the supervision of the division of corporations, department of investments. Most states have regulatory legislation and have set up what is known as credit union law. In California, this is found in Chapters 382, 419 and 497 of the financial code, Statutes of 1951, and is a recodification of the original California Credit Union Act, approved March 31, 1927. Those states having specific regulations governing credit unions have mainly followed the original New Hampshire law and the law for Massachusetts, which was second in the field.

The other type of credit union is known as a federal credit union. These credit unions are organized and directly supervised by the Bureau of Federal Credit Unions, Federal Security Agency. While there is a constantly growing sentiment against the intrusion of government in the field of hospital management, it will be found that the bureau is not objectionable. Rather, the supervision is nearly identical with that accorded national banks under the National Banking Act. The records and operations of the individual credit union are reviewed periodically by competent examiners. When the public interest, including that of the members, seems to advise it, examining agents may require that specific action be taken.

SUPERVISION IS SALUTARY

Many credit unions have liquid assets in excess of $500,000. While the governing board of the hospital is not liable for a credit union organized by its employes, the hospital administrator will readily recognize the salutary effect of bank examiners on the operations of the banking system of this country. To no less extent will the constant supervision of the bureau of federal credit unions assist in maintaining a sound and efficient credit union for the employes of the hospital. As an example of careful supervision Art. XV, Sec. 4 of the by-laws for federal credit unions reads as follows:

"A cash fund for the purpose of making change may be established by the directors, by resolution, in an amount not to exceed $100. On all cash funds in excess of $100 the board of directors shall obtain the written permission of the director, Bureau of Federal Credit Unions, Federal Security Agency."

A successful credit union requires that there be members who will deposit funds — for savings and for dividends — and members who will borrow money. The interest paid by the borrower carries the expenses of operation, provides a cash reserve for bad accounts, and pays the dividends to those who invest. Although there have been instances of successful operation with a membership of 100 to 150, these are unusual. It is probably safe to say that the hospital should have about 200 employes, as a minimum, for credit union organization.

*Smoor, Pieter: Credit Union Saves Money and Serves Morale. Mod. Hosp. 64:54 (February) 1945.

Small hospitals, those with 25, 50 or 100 employes, can still organize, provided there are a number of the smaller institutions in a contiguous area with some sort of correlating organization, such as a local hospital council or conference. The federal credit unions may organize under the provisions of Art. II, Sec. 1:

"The field of membership shall be limited to those having a common bond of association, occupation, or residence."

It was under a federal charter and the provisions of the section quoted previously that the 12 member hospitals of the Hospital Council of San Diego County recently organized their Cabrillo Hospitals Federal Credit Union. Of the 12 members, one is large (700 beds), two are medium (124 beds), and the remaining nine are small (under 60 beds). The seven directors, the officers, the loan committee, and the supervisory committee were selected among all the participating hospitals. The various institutions are close enough together to make a smooth running organization.

THERE IS NEED FOR SPEED

If a council sponsored credit union is planned, it should be remembered that, while deposits can easily be made by mail, loans often are required with the utmost dispatch. A three-man loan committee must first approve the application in writing. Then, the treasurer must draw a check, which requires a second signature by another officer. If the credit union is group operated, each of these five individuals is probably—and should be—in five different institutions. These, of course, are drawbacks. But if each of the hospitals involved is too small to set up a credit union, the very fact that group cooperation has made the credit union possible confers on the employes of the area advantages that far outweigh the disadvantages.

The actual mechanics of organization are exceedingly simple and the credit union league (identical with a state hospital association) for the particular state will provide all necessary forms and instructions. A complete kit of every form necessary for the formation and operation of the credit union, including books of account, is supplied at a cost of $40 (California price). The league also will send a representative, at no charge, to advise and hold the required organizational meetings.

The procedure for setting up a credit union includes (1) selecting the seven incorporating directors from among the employes, and (2) signing the charter application and forwarding it to the regional office, with the statutory fee of $25. The charter will be issued within days and an organizational meeting, at which officers are elected from among the directors, should be held.

Other employes may now join the group. This is done by filling out a simple application card and presenting it, with the small fee of 25 cents, to the treasurer. The application is later approved by the directors.

Members are not obligated to save any specific amount; they may save just what they wish. The credit union will constantly urge that savings be regular, however, even though they are in small amounts. The habit of thrift requires nothing but will power. A member who saves 50 cents a week is developing a regular savings habit and will usually be a much beter member than one who saves larger amounts only spasmodically.

There is an additional incentive for saving besides the dividends that will be earned. This is the life insurance policy that is issued to each member with a savings account. The policy is equal to the amount of his savings. The premiums on this insurance are paid by the credit union and are a part of its operating expense. For example, an employe with $1000 saved and on deposit will not only earn the regular dividends on this amount but will receive a paid up life insurance policy for a like amount for the beneficiary of his choice. The insurance is in force for as long as the money is kept on deposit. Should the member draw out $500 for some purpose, however, his life insurance coverage will drop to the amount of deposit remaining: in this instance, to $500. Should all funds be withdrawn, the insurance protection ceases.

If the employe should leave the hospital field or go to a position remote from the location of his original credit union, he may still retain membership, receive dividends and maintain the insurance policy. He can always borrow from the parent group by mail, the security in this instance being the amount of savings on deposit.

Most credit unions limit the amount of savings to $1000 per member, the reason for this being that no one individual could, by a preponderance of deposits, obtain control of the credit union. As the immediate family members of the employe are eligible for membership, it is possible for a husband and wife each to have $1000 earning dividends and also have two $1000 life insurance policies.

No formality or physical examination is required for this life savings protection. Up to age 55 the savings are matched dollar for dollar by life insurance. After 55 years of age the insurance protection drops to 75 per cent of the savings, with a corresponding drop until age 70 is reached. Deposits that are made after the employe has reached the age of 70 are not covered by insurance.

PROTECTION AGAINST "RUNS"

Members may withdraw their savings at any time upon demand exactly as they would from their bank savings accounts. To protect the credit union against any possible "run" there is a provision in the by-laws, rarely invoked, that a member is required to give the group a period of notice on share withdrawals. In most instances the member merely presents his passbook and receives a check from the treasurer.

Loans are made to members for provident and productive purposes at an interest rate of 1 per cent per month (or less) on the unpaid balance. This is a true 12 per cent annual interest rate. As an example, if a member borrowed $100 at 1 per cent per month for 10 months and made principle payments of $10 per month, he would pay $5.50 in interest. Assuming that the employe had the security and could borrow the same $100 from a bank, he would either receive $94 and repay $100, or receive $100 and repay $106. This is an *interest* rate of about 14 per cent, the difference being that banks operate on the basis of a 6 per cent *discount* rate, while credit unions operate on a 12 per cent *interest* charge.

What is a simple explanation of this astounding fact? If you used the $100 for one year, with no payments, and repaid $106 at the end of 12 months, the true interest rate would be 6 per cent. But banks could not stay in business on such a return. The *discount rate* method used by all banks, loan companies, finance companies, and any firm in the business of supplying consumer credit, does *not* take into account the declining balance of your loan as payments are made. True interest always is computed on a declining balance and number of days used. The best example of this is found in mortgage and trust deed loans.

INTEREST RATES CLIMB

The comparison was made previously between a bank loan and a credit union loan. There is no criticism of the bank for its 14 per cent interest rate; interest paid a bank is the cheapest and probably the most legitimate in the consumer credit field. From the 14 per cent charged by the bank, interest rates on other types of loans climb almost into the stratosphere. Two examples will suffice.

A tray girl in a hospital borrowed $15 from a loan company. The loan was repaid in 30 days, plus an interest charge of $3.50. The annual interest rate in this case was 280 per cent. Another case, and more tragic, concerned a janitor. He borrowed $5 from a loan company with an interest payment of $1 per week until the loan was repaid. The amount owed eventually reached $435 and the janitor's salary was garnisheed. The interest rate in this case was 1040 per cent! These are not isolated examples at all. Any hospital personnel director could probably add many more.

The worst offenders are not always the personal loan companies. They make their rates crystal clear and only extreme emergency should drive an employe into their offices for a loan. The group that appears to do the most harm are the appliance and "gadget" salesmen. Their appeal of 50 cents down and $1 a week is irresistible to many hospital employes. In many cases, these folk are not interested in repossession of the article purchased, should difficulty arise in the payments. The full contract price is enforced in the local courts. The personnel and pay-roll departments have extra work with attachments or garnishments, and, most important, the hospital has a worried despondent employe who is far more of a liability than an asset to the institution. If Jane, the nurse's aide, wants a television set, she is wiser and many, many dollars ahead to borrow the cash purchase price from her credit union. The loan may then be repaid on terms she can afford—up to 36 months—by pay-roll deduction and with a true interest rate of 12 per cent per year.

Borrowing from a credit union is a simple process. A simple application form is used. The applicant need only state how much he wants, the purpose of the loan, and how he wishes to pay it back. The credit committee passes on the loan, and, if acceptable, it is given to the treasurer who issues the check. Under the condition of a federal credit union loans up to $200 may be made without security other than the member's promise to pay. Loans in excess of this amount may be made on the security of deposits in the union, co-signed by a fellow employe, or a chattel mortgage.

The life insurance on savings was mentioned previously. Similarly, all loans are covered by a "loan protection" insurance policy on the life of the borrower. The premiums are paid by the credit union with the additional feature that protection is extended in cases of total disability as well as death.

EXAMPLES OF BENEFITS

Many examples could be given of the convenience and benefit of credit union operation. One common practice is for the member to borrow $1000 from the union and turn right around and deposit $1000 to his credit. In fact, he never sees the money — the deposit is security for the loan. Two $1000 life insurance policies are issued, one on the loan and the other on the deposit. The member receives full dividends on his $1000 deposit and pays interest on the payments. Assuming an annual dividend rate of 4 per cent, the employe pays an adjusted interest rate of about 8 per cent. The net result, if the member is over 31 years old and under 55 years, is $1000 of life insurance (on the deposit) at a cheaper cost than that possible from private insurance carriers. Should he die, before even one payment is made on the $1000 loan, his estate would receive $2000 free and clear.

Participation in the ownership of a business corporation, like General Motors or United States Steel, is evidenced by shares of stock. Similarly, membership in a credit union is based on shares which are generally fixed at $5. This small amount enables a member to earn a dividend quicker than if the shares were set at $50 or $100 each. Shares are purchased by the periodic savings of the members and are evidenced by entries in the credit union passbook.

CONTROLLED BY MEMBERS

The control and management of a credit union rest entirely in the hands of its members, the employes of the hospital or group of hospitals. The only function of management is to assist by providing space for the office and by providing pay-roll deductions for savings or the repayment of loans. The administrator and department heads should participate, if possible, by becoming members and putting funds on deposit. They should not hold office, as one of the features of a credit union is that it is "by employes and for employes." While the administrator is actually an employe of the hospital, this fine point is usually lost on most of his subordinates.

At membership meetings, both annual and special, each shareholder is entitled to one vote. The basic credit union principle is "one member, one vote." In industry, not infrequently the annual meeting will be presided over by a worker from the shop while the general superintendent sits in only as a member with one vote.

The experience of industry has shown that a good employe credit union has a definite effect on improving employe morale. As each new employe joins the organization, the personnel department furnishes him with an introduction to the plan The educational committee of the credit union follows this up by explaining to the new employe the benefits and urging his participation. In most cases a new employe may become a member at once and start his share purchases (savings), but he is not eligible for a loan until 90 days, except under unusual circumstances.

How easy are "easy-payments"? In attempting to answer this question, the average hospital employe is likely to rely on adjectives instead of arithmetic. As a result, he has a difficult time with easy payments. The formation of a credit union within the hospital or group of hospitals is a simple effective way of keeping employe morale high and helping each individual worker help himself.

Efficient patient care results from making the best use of the NURSING TEAM

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Division of Medical and Hospital Resources
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HOW can good nursing care be provided economically? This question is frequently asked by hospital administrators, nursing service directors, medical and community leaders. Nurse-patient assignment is of special concern to directors of nursing service, nurse supervisors and head nurses. After they ascertain with the medical staff, the administrator and department heads, what patient care and service functions will be performed by nursing service personnel, and what functions will be assumed by the medical staff and other hospital departments, they have to decide how best to utilize nursing personnel to provide the desired care and service.

SHE HAS SEVERAL CHOICES

The head nurse on a hospital inpatient unit has a choice of several nurse-patient assignment plans. She can use the "Case Method" (Chart 1). Under this method the head nurse directs each graduate registered nurse and nursing aide in giving complete nursing care to one or more patients, including general nursing measures, treatments, taking of temperatures, and instructing in health.

The case method has advantages. Patient care is individualized to meet the needs of each patient. The nurse gets to know her patient and is able to observe his symptoms. There is great satisfaction for the nurse and for the patient who does not have to adjust to so many persons. Under this method of assignment, nursing education and care become patient-centered.

However, the case method presents several difficulties inasmuch as not all nursing personnel is capable of giving complete care to all patients. The nonprofessional worker and the practical nurse or nursing aide can give only partial care to certain patients. This method is expensive and extravagant because the graduate registered nurse performs many functions that could safely be done by the nonprofessional nurse. All supervision must be done by the head nurse. It is almost impossible to use this method efficiently in present day hospital practice.

The "Functional Method" (Chart 2) is another choice of nurse-patient assignment. Nurses and other nursing employes are assigned to specific functions, such as giving medicine or treatments, taking temperatures, or giving general nursing care to a group of patients.

The functional method is efficient because more work can be accomplished in a given time with fewer interruptions and less confusion. The method uses nursing personnel with different qualifications for appropriate duties, and skill in performing functions is developed as these functions are repeated frequently.

However, there are objections to the functional method. Patient care may become function-controlled rather than patient-centered. Patients must adjust to a larger number of nursing personnel, while some patients may receive little or no attention from the professional nurse. Also, the head nurse has all the supervisory responsibility.

There is a third method of nurse-patient assignment, the "Team Method." A group of nursing personnel, the "Nursing Team" (Chart 3-Chart 4), works together toward the common goal—good nursing care. A professional nurse is assigned as "team leader" and becomes responsible for a group of patients. Nursing aides or practical nurses are assigned to assist the leader.

PLANNED AS A TEAM

This is how the plan functions. The team leader under the general direction of the head nurse plans with her team all the nursing care required by the patients in the group. She identifies the nursing problems of each patient (physical, mental, emotional, spiritual and special). The leader interprets the nursing problems to her co-workers and by daily and informal conferences seeks their cooperation in planning. She formulates a nursing care plan and keeps it up to date. (A special "nursing care card" is useful.) She differentiates and delegates nursing care for all patients in the group. The leader directs the programs of nursing care by being available, willing and able to assist or to teach as required. With the team she evaluates and records the results of nursing care. (A daily conference to evaluate patient care is helpful.) She cares for selected patients and assists other members of the team with patient care functions as required.

The advantages of the team method are many. It provides nursing care that

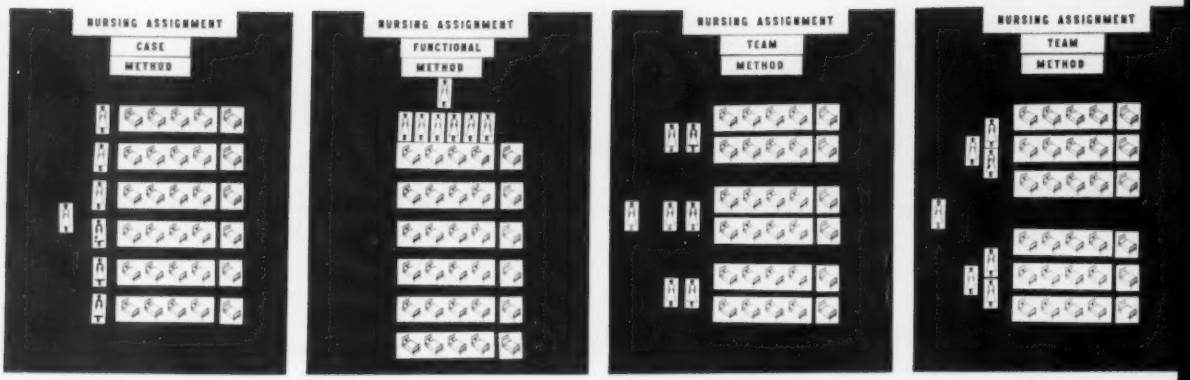

CHART 1 CHART 2 CHART 3 CHART 4

Chart 1: Assignment of 24 patients on a 30 bed nursing unit on the a.m. shift, utilizing one head nurse, three graduate general staff nurses, three practical nurses or nurse's aides by the case method. Chart 2: Assignment of 24 patients on a 30 bed nursing unit on the a.m. shift, utilizing one head nurse, three graduate staff nurses, three practical nurses or nurse's aides by the functional method. Chart 3: Same assignment as Charts 1 and 2, utilizing three nursing teams: 1:1 ratio professional to nonprofessional personnel; total staff is one head nurse, three team leaders (graduate R.N.'s), three practical nurses or nurse's aides. Chart 4: Same assignment, utilizing two nursing teams: 1:2 ratio; total staff is one head nurse, two team leaders (R.N.'s), and four practical nurses or aides.

is patient-centered rather than job-centered; nursing personnel cares for the patient as a *person*. Efficient patient care results from making the best possible use of the abilities of the team members, *i.e.* better utilization. Fewer people are needed to perform the functions for each patient. The graduate registered nurse is given more responsibility, at the same time she is being relieved of many time consuming, nonprofessional tasks. Thus she has more time to spend with the acutely ill patients. Team organization gives her more time for teaching and guiding the nonprofessional worker.

The team method permits each worker to function according to her abilities and preparation and to contribute her share to the team's function of "good nursing care for all patients." There is more personnel satisfaction. An esprit de corps, a spirit of working with (rather than for or under) someone is developed. The graduate registered nurse knows that her abilities and skills are being used to advantage and that the patients are receiving good care. The patient recognizes that the nursing personnel is working together for his safety and comfort. The head nurse is relieved of the details of first-level supervision and she therefore has more time for planning, organizing and supervising the entire unit.

For the successful functioning of the team plan, the feeling for teamwork must be present throughout the hospital. The team concept must permeate the philosophy of the nursing service department before it can function in the various units. All nursing personnel and the medical staff must be familiar with and believe in the team plan.

In addition, supervisors and head nurses must have the ability to organize and supervise. All nursing employes must be familiar with the policies and practices of the hospital and their duties must be clearly defined. Student nurses must learn to work as part of the team.

Especially necessary is the good team leader. The leader must be a good nurse, capable of giving good bedside care. She must know teamwork and believe in the team plan and have enthusiasm for it. She should have mature judgment and interest in the broadening field of nursing and insight into the need to depend on the team rather than upon herself. She must feel the importance of and the necessity for her rôle as team leader.

The proportion of graduate registered nurses on the team will vary with the number and kind of patients and the qualifications of personnel on the team. One study of team assignments on an active medical-surgical unit revealed that a ratio of one professional nurse to two nursing aides was most effective. This hospital conducts a well organized in-service training program for nursing aides and had been using the team assignment for about one year. When a one-to-one ratio was used, the professional nurse performed many functions which safely could be delegated to a nursing aide. When the one-to-three ratio was used, the professional nurse worked beyond normal limits and spent all her time supervising the nursing aides, administering treatments and medications, preparing patients for surgery, and charting. She had no time to perform bedside nursing care of patients whose condition required her attention.

The nursing team method of hospital care is based on the democratic principle of working together for a common goal and should provide better patient care in both large and small hospitals.

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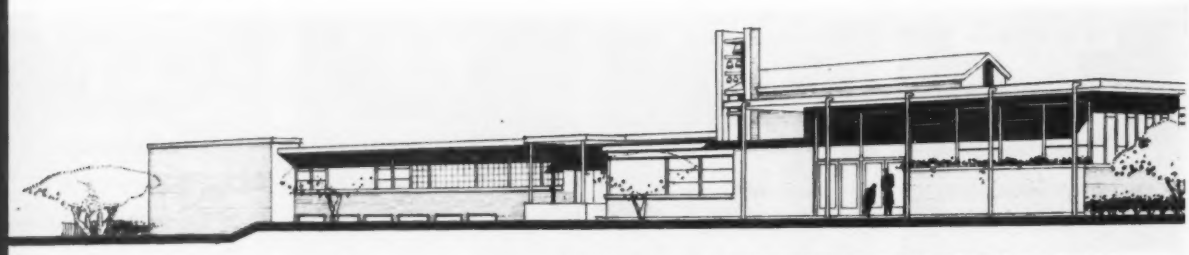


ARCHITECT'S RENDERING OF PIONEERS MEMORIAL HOSPITAL, ROCKY FORD, COLO.

THE MODERN HOSPITAL OF THE MONTH

Pioneers Lives Up to Its Name—

in architecture and administration

CHARLES H. KELLOGG
Architect, Denver

PIONEERS Memorial Hospital of Rocky Ford, Colo., is designed to serve this town of 5000 population and adjacent small communities in the western section of Otero County. Rocky Ford, situated near the early river crossing of the Santa Fe Trail, is a center of ranching and agriculture in the rich Arkansas Valley.

Several important and unusual features in community organization and administration determined basic design features of the hospital.

For years, citizens of this area have obtained hospitalization at La Junta, the county seat, which boasts two hospitals: the Mennonite Hospital of 87 beds, and the Santa Fe Hospital of 40 beds. Public spirited citizens of Rocky Ford and smaller towns to the west, however, felt the need of a small hospital of their own to serve their needs.

Surveys determined a need of 25 beds for the Rocky Ford area, plus adequate housing for a branch of the Otero County Health Department, which has its main offices in La Junta.

Funds were raised by enthusiastic public contributions which, together with money made available through the Hill-Burton Act, will cover the cost of this project.

The desire to provide high quality service at the lowest possible cost to the patient and a cooperative attitude on the part of the Mennonite Hospital in La Junta prompted the Rocky Ford Hospital board to enter an agreement with the board of control of that institution whereby the new 25 bed hospital and public health center will be operated as a branch unit, in a coordinated system of health facilities in Otero County.

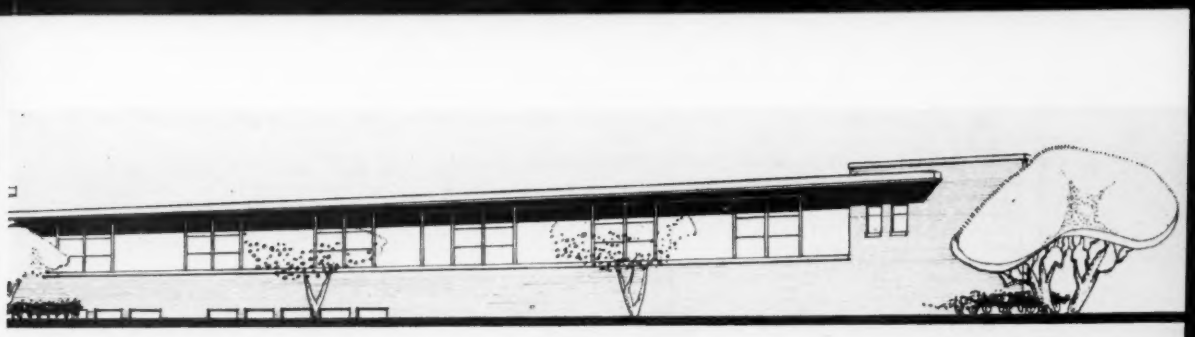
The administration of the Rocky Ford unit will be under the supervision of the administrator at La Junta and will be controlled in its operation by the same board of control as the parent institution has. Departmental supervision will be given by the department heads from the Mennonite Hospital. It is anticipated that the affiliation of the Rocky Ford Hospital with the Mennonite Hospital will result in a scope of service and activity not usually found in an institution of this size.

There will be one medical staff for the two institutions. The Pioneer Memorial Hospital medical staff will be organized with both constitution and by-laws identical to those at the Mennonite Hospital. Benefits derived from teaching teams from the University of Colorado School of Medicine, which regularly visit the area, will be realized by both. The smaller unit will also benefit from the direct visiting services of the specialists in radiology and pathology now serving the Mennonite Hospital.

Students from the Mennonite school of nursing will receive part of their training at the Rocky Ford unit, thus offering student nurses valuable experience in small community hospital problems.

A break with tradition has been made in the design and layout of patient rooms. With beds in opposite ends of the rooms, many advantages will result that are not found in the conventional two-bed room. Because full fenestration is being provided in each room, solariums are not needed. Each patient room has either a private or connecting toilet opening off the room, equipped with bedpan lugs and spray attachment for flushing and rinsing. Toilets and storage space are in the less desirable spaces of the building and adjacent to the corridors. All but three rooms are designed to accommodate two patients, although in

The architect gratefully acknowledges the helpful consultations and recommendations given him by the hospital facilities and hospital standard sections of the Colorado State Department of Public Health in the development of plans for this hospital building. Consultation advice also was obtained from the dietetic department of the University of Colorado school of medicine, from practicing radiologists in Denver, and from the administrative staff of Mennonite Hospital, La Junta.



normal operation a number, as shown, will be set up as private rooms.

Two of the three strictly private rooms comprise the isolation suite. Both rooms in the suite have private connecting toilets and showers and are connected by a subutility room. Thus, this unit may be used for isolation; for de luxe private accommodations, or for seclusion rooms for mildly disturbed mental patients. This suite achieves maximum flexibility in meeting desires and needs of patients.

There are nursing stations in both the medical-surgical wing and the maternity wing. The office of the superintendent of nurses, located at the junction of the corridors, will be completely fitted as a nurses' station. During the day, when student nurses are receiving instruction in Pioneers Hospital, the nursing stations in the separate wings will be used. At night, when personnel is at a minimum, nursing supervision will be exercised from the office of the superintendent of nurses. Chart racks are on wheels, easily moved from the nursing stations to the night station. This arrangement gives consideration to the most efficient use of costly personnel and space. A classroom has been provided in the nursing unit for the instruction of student nurses.

Of particular interest is the arrangement of the laboratory, the x-ray room, the radiologist's office, and the lounge and conference rooms. The absence of windows in the x-ray room eliminates the disadvantages of lightproof shades. One technician can easily handle both x-ray and laboratory under reasonable usage. An office has been provided for a visiting radiologist for scheduled half-days. A folding door, separating the radiologist's office from the lounge and conference room, permits the use of either room, or the combined rooms, for gatherings of professional personnel for various types of meetings. A recessed seat for outpatients is adjacent to double dressing rooms and will eliminate congestion in the north-south corridor when outpatient clinics are held. This makes possible more working space for the x-ray equipment.

The darkroom and toilet in the x-ray suite are outside the main building line, allowing more working space and a better planned x-ray unit.

The emergency room, adjacent to the ambulance entrance, is convenient to other facilities, such as x-ray, laboratory and surgery. Owing to the strategic location of the central sterilizing and supply department, which provides service for the entire house, only one small substerilizing room off the operating room was necessary.

The large labor room also provides for emergency delivery facilities.

Careful consideration was given to the comfort and needs of the physicians and nurses in the spacious dressing rooms and lounges in the operating-delivery wing.

A chapel seating approximately 40 people is so located that it may be used by groups for public meetings related to the health program of the community, as well as for public health clinics and the morning chapel program, without disturbing normal hospital routine. A common exterior entrance serves both the public health unit and the chapel.

The layout of the administrative suite facilitates the admission of patients from the waiting room to the hospital and provides for the economical use of personnel to serve the record room, the admission room, and the general office. The south end of the record room, for the use of physicians, is soundproof. A recording system, connected to a recording unit in the medical records room, provides dictating units in each of the two main nursing stations and the doctors' lounge.

In addition to the communication system for medical records, the following systems are provided:

1. A complete two-way electronic system between patients' bedroom and each of the nurses' stations to supplement the nurses' call system.

2. A speaker in each patient's room for reception of radio broadcasts or programs originating in the chapel.

3. An intercommunicating system between the administration office, nurses' stations, superintendent of nurses' office, surgery corridor, delivery corridor, maintenance area and kitchen.

4. Adequate telephone service throughout the house in addition to a public pay telephone near the waiting room.

A centrally located pantry on the first floor adjacent to the elevator provides storage space for liquid nourishments but is not intended to provide space for tray service or other food service functions. These latter services will be taken care of from the kitchen, located in the basement.

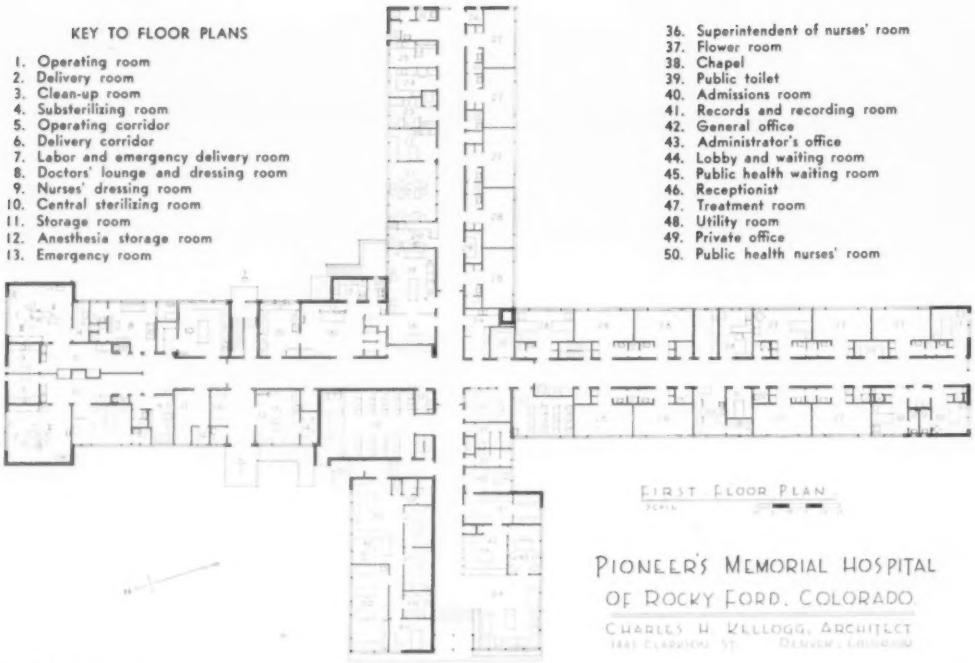
Kitchen, storage areas, and employes' locker rooms in the basement area are situated to reduce travel to

COSTS

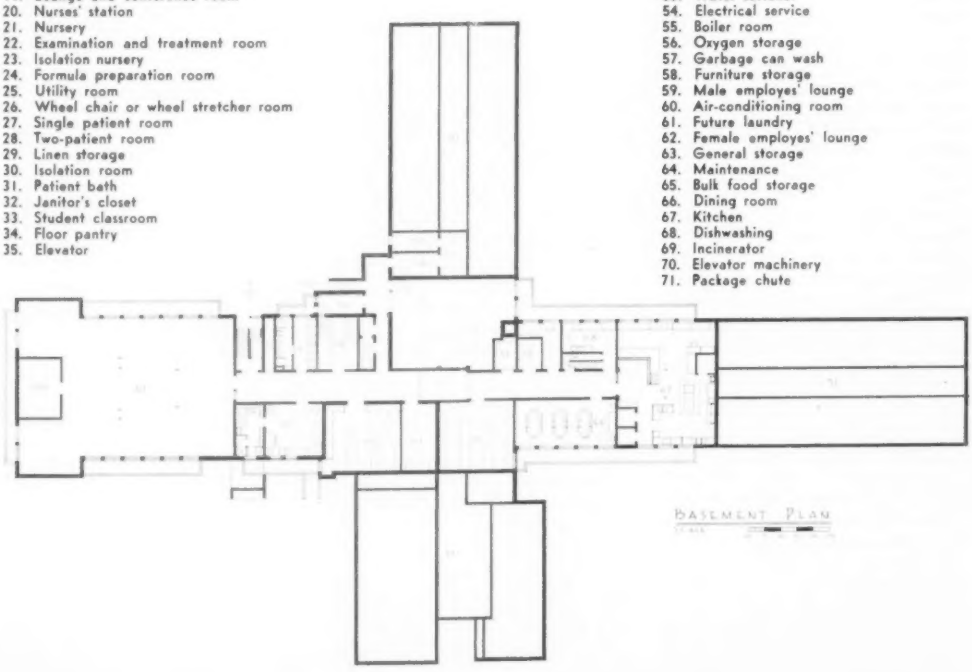
Estimated Total Project Cost	$444,383.00
Estimated Cost per Bed, 25 Beds, Including Fees, Public Health Unit, Chapel and Group I, II and III Equipment	$ 17,775.00
Estimated Cost per Square Foot	$ 15.10
Total Square Foot Area	29,696
Total Cubic Feet	299,564
Cost per Cubic Foot (Total Funds)	$ 1.48

KEY TO FLOOR PLANS

1. Operating room
2. Delivery room
3. Clean-up room
4. Substerilizing room
5. Operating corridor
6. Delivery corridor
7. Labor and emergency delivery room
8. Doctors' lounge and dressing room
9. Nurses' dressing room
10. Central sterilizing room
11. Storage room
12. Anesthesia storage room
13. Emergency room
14. Splint and cast room
15. Laboratory
16. X-ray room
17. Darkroom
18. Radiologist's room
19. Lounge and conference room
20. Nurses' station
21. Nursery
22. Examination and treatment room
23. Isolation nursery
24. Formula preparation room
25. Utility room
26. Wheel chair or wheel stretcher room
27. Single patient room
28. Two-patient room
29. Linen storage
30. Isolation room
31. Patient bath
32. Janitor's closet
33. Student classroom
34. Floor pantry
35. Elevator
36. Superintendent of nurses' room
37. Flower room
38. Chapel
39. Public toilet
40. Admissions room
41. Records and recording room
42. General office
43. Administrator's office
44. Lobby and waiting room
45. Public health waiting room
46. Receptionist
47. Treatment room
48. Utility room
49. Private office
50. Public health nurses' room
51. Not excavated
52. Salt storage
53. Water softener
54. Electrical service
55. Boiler room
56. Oxygen storage
57. Garbage can wash
58. Furniture storage
59. Male employes' lounge
60. Air-conditioning room
61. Future laundry
62. Female employes' lounge
63. General storage
64. Maintenance
65. Bulk food storage
66. Dining room
67. Kitchen
68. Dishwashing
69. Incinerator
70. Elevator machinery
71. Package chute



FIRST FLOOR PLAN



BASEMENT PLAN

PIONEER'S MEMORIAL HOSPITAL
OF ROCKY FORD, COLORADO
CHARLES H. KELLOGG, ARCHITECT
1441 CLARKSON ST. DENVER, COLORADO

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects and the state officials. A similar award will be made by The Modern Hospital each month.

stairways and elevator. The centrally located boiler room divides the building into four temperature control zones.

Particular attention is invited to the layout of the kitchen and related facilities. The serving counter and steam table serve a dual purpose: (1) to provide cafeteria service for employes, and (2) to facilitate patient tray service preparation. Raw food deliveries to the kitchen area do not conflict with the adjacent food preparation area. Inasmuch as this kitchen will be staffed by two people, it was important that the distance from food storage to food preparation, to cooking area and on to service area be kept at an absolute minimum, while still allowing for easy circulation and functional flow of the food as it is prepared and served. Day storage is immediately handy to the cook's table and stove. A small alcove has been provided for the consulting dietitian. The arrangement in the dishwashing room provides for a continuous flow of used dishes through the dishwashing machine into the tray setup area immediately behind the service counter in the kitchen.

Patients' trays will be delivered in heated carts via the elevator.

Ample space has been provided for storage of all kinds. Oxygen will be piped to each patient room, the nursery, the operating room, the emergency room, and the delivery room. Delivery of oxygen tanks to the oxygen storage room is made directly from the delivery service area in the rear of the hospital.

The excavated, but unfinished, north portion of the basement may be used for a future laundry should this become desirable. At present, laundry will be handled at the Mennonite Hospital in La Junta.

The small stairway immediately adjacent to the kitchen area is designed solely for the use of hospital personnel.

The x-ray and darkroom toilets, and the operating and delivery rooms have mechanical ventilation. The operation and delivery suites have, in addition, provision for controlled humidity. Low-pressure steam is used for general heating and humidity control. High-pressure steam is supplied for sterilizers, dishwashers, steam cooker, and so forth.

There is space in the public health unit for three public health nurses, for a sanitarian, and for clerical personnel. Necessary treatment and examination rooms are included. A separate waiting room will eliminate congestion and confusion, which might result in a common hospital-public health waiting room. This unit is not the complete county health department facility, but rather has been designed primarily to serve the public health nursing and clinic needs of the people in the western part of Otero County. The location and arrangement of the public health unit afford easy access to the chapel and to the hospital for necessary outpatient facilities, without interference with normal hospital operation.

Construction is of masonry for exterior and corridor walls. Interior partitions are of gypsum block. The main floor is of concrete slab on steel joists, with asphalt and rubber tile or linoleum covering. The roof is of wood frame with 20 year bonded roofing.

A carillon, the gift of a friend of the hospital, is to be installed in the chaste bell tower, which is symbolic of the spirit of Christian brotherhood and sympathy on which this institution was founded.

Dedicated to Research

CEDARS OF LEBANON HOSPITAL in Los Angeles recently dedicated a new building, specially designed and constructed to serve the needs of laboratory research. The building stands as a memorial from Mr. and Mrs. Tom May to their daughter, Blanche, and houses Cedars' Institute for Medical Research, one of the few establishments for laboratory and experimental research maintained by hospitals in the United States. Director of the institute is Dr. Harry Goldblatt.—GERTRUDE BINDER, *director of public interest, Cedars of Lebanon Hospital, Los Angeles.*

Visitors arrive for the dedication of the new Cedars of Lebanon Institute.

In nursing homes the accent belongs on HOME

MARGARET HEALY, R.N.
Director of Nursing Service
Shore View Nursing Home
Milwaukee

THIS life we are living is divided into three stages. We speak of having a childhood, a middle age, and an old age. Now it's strange that during childhood we're not quite aware of childhood. During old age, we're not always aware of that either—nor do all of us reach it.

It is during the so-called "middle age" that we are very much aware of living and enjoying life, and it is the period in life when we are best able to look after those who are coming along in childhood, and those who are going along into their final years.

To look at these two groups of human beings—the infants and the aged—is to be struck by the enormous differences which mark them, making them totally unlike one another, and no more comparable than black is to white.

THERE ARE SIMILARITIES

This general impression of contrast, of opposition, is one which comes through hurried observation. But we who have had the opportunity to make friends with old people, and who have been able to help make their late years rich years, cannot avoid noting the similarities between old age and infancy.

Our old patients in nursing homes need as much care as do the young ones in the maternity ward. The dietitian in the nursing home must select the proper foods, plan special diets, and have them properly prepared. Meals must be served with the same regularity that pabulum and formulas are served to infants. For some the feeding time will be on the demand basis as is the present fad for the growing infant.

From a paper presented at the Tri-State Hospital Assembly, May 1952.

Some of our patients in the nursing home are, like the infant, totally helpless and would perish if left to themselves. We have others who need additional care because they are both aged and chronically ill. Fatigue makes them cranky and irritable. Many, like infants, present feeding problems and must be induced to eat by coaxing or by serving them only their favorite food. They are restless, dissatisfied, change their clothes frequently or protest against any change at all. They experience fear and insecurity; they need the reassurance of being wanted, of gentle affection, of kind direction without regimentation. Truly, they are once a man and twice a child.

In both institutions—the nursing home and the maternity hospital—it is the practice of patience and the devotion of the staff, not regimentation, which make the patients happier and sometimes healthier human beings.

Now here is something which seems very strange with regard to infants and the aged, and with the aged I include the chronically ill.

Society recognizes the fact that it will always have infants. To care for them hospitals are set up. Doctors study the physiology and psychology of infants, and large endowments are left to further the care and study of infants. Society is well equipped to protect and promote their health.

When there's an infant in the family, special foods go on the pantry shelf, special clothes are bought, special furniture goes into the nursery. The sleeping time of the infant sets the clock for nearly everything else that is done in the household.

Now it's certainly a fact that just as society has infants, it will always have elderly people, unless, of course, somebody finds the fountain of youth. But what does society do about its elderly people? Society says it has a *problem*—"the problem of the aged." "What are we going to do with our aged?" "We must meet the problem now or very soon the aged will be our greatest burden."

THEY DESERVE LOVE AND CHARITY

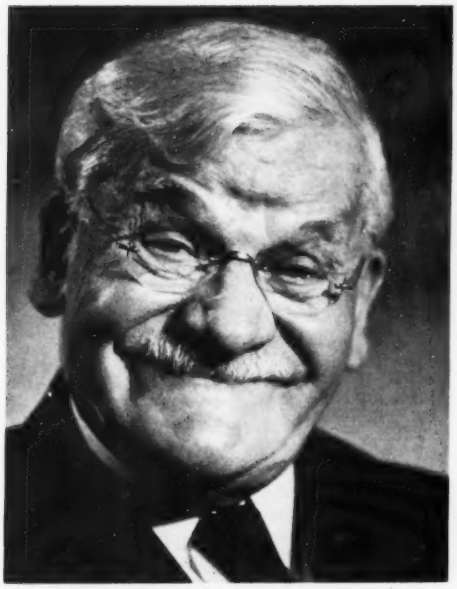
It seems to me that older people are as much human beings as our infants are. Why, then, can't we show these older people the same love and charity that we try to give our infants, or any other group in society?

We don't hear anything about the "infant problem." No, because infants are recognized as members of society and are fitted into the social pattern. Now, just as infants are given their natural place within the family, I believe our older people should be woven into family life, where they naturally belong.

Their presence will demand sacrifices, it is true, but isn't the happy family built on sacrifice? The presence of old folks in the family circle should develop in its members that love, devotion and selflessness which distinguish man from the brute animal.

Looking, then, at the nursing home as the substitute for one's natural home, it should be made as much like home as possible. Let us look at its responsibilities and its problems.

Our first responsibility is to the patient. We are not merely keeping him alive; we are making him feel, and hope, and realize that life is still worth living. This, of course, is diffi-



"Old people are human beings, too . . ."

cult to do, especially when the mental and emotional capacities remain well preserved, but the physical abilities have deteriorated. This physical unfitness makes the patient lose interest in life. It is difficult also when physical vigor is still maintained, but senility has caused the mind to remember only the past, and to be totally unaware of the present.

As nurses we must realize that we are caring for living human beings, who have grown old according to the particular pattern of life in which they lived. These patterns differ from one patient to the next; to harmonize them all into the pattern of life which exists in the nursing home is a task which requires daily attention.

A 91 year old woman, a patient of ours in Milwaukee, said that at 91 all one can do is think. "Life resolves itself into a series of petty problems connected with mere physical existence and the endeavor to fit these problems into a pattern, because I can do nothing without a nurse. A nurse for the aged should have the highest standards for nursing care and should deal honestly with the patients." When I asked her what she meant by "deal honestly," she said, "Well, the nurse shouldn't say I'll be back in a minute and then not come for five hours."

It seems we are inclined to forget at times how much the patient depends on the nurse. For some patients, the nurse means sight. For some the nurse means hearing. The nurse is the arms of those who cannot use their own, the legs of those who cannot walk, the back for those who cannot turn.

Out of this dependency flows the problem of getting qualified personnel to staff our nursing homes. It is too often the case that nursing home employes are ill fitted for the challenging work, and the almost "motherly" duties they take on.

To protect ourselves against the infiltration of inferior personnel — people uninstructed in the care of the sick and the aged, people who drift in and out of the field according to their own economic need, people who by temperament are natural opponents of the aged — to keep such personnel outside the field of nursing is the responsibility of all of us.

Applicants must be screened carefully and those whose undesirability is quite clear must never be given the opportunity to acquire "experience" in the field. It is this "experience" which enables them to float from one institution to another, doing good for nobody, especially not for the aged.

Young people make fine company for elderly people. It has been my experience that part-time workers of high school and college age, who are genuinely interested in people, are fitted by youth with a family of qualities which harmonize well with the idiosyncrasies of the aged, and age loves youth.

This desire to serve is important because service to the patient is frequently rendered unseen; no one but the nurse herself knows its quality, and she alone knows when it's neglected. A sensitive conscience or a feeling of responsibility is a prerequisite for anyone put in charge of elderly people whose welfare depends upon the mercy of others.

The nursing home has a responsibility to the relatives of its patients, for these usually are the people most interested in the aged and most concerned over their physical and mental comfort.

There are, of course, the usual services which the nursing home extends to the relatives, such as frequent reports on the patients, common courtesies during visiting hours, an understanding attitude when payments must be delayed, and all the other little things which hurry *us* to our own old age. But what is extremely important is that we communicate to the relatives a clear notion of just what *old age* is. It's important that they get a clear notion of just what a *nursing home* is.

BUT GRANDPA DOESN'T CHANGE

People sometimes think that as soon as Grandpa steps into the nursing home, he changes into a completely new man. They think his noisy spells are over, that he no longer worries about his money, or suspects nine different people of being thieves who are after it. They think that in the nursing home he'll be able to hop about like a boy scout and take his meals like a lumberjack.

Consequently, on visiting day when Grandpa is found to be up to his same old tricks, the relatives are quick to classify the nursing home as a failure of the first order.

Now to dispel these faulty conclusions, the nursing home must cultivate favorable public relations with the friends of its patients. These friends must be educated by us, in a gracious and gradual way, to a better understanding of the nursing home, and of the old folks whose home it is.

(*Continued on Page* 66)

Frequent visits must be encouraged. If the patient needs new clothing, or more changes of clean clothing, relatives must be informed of the need. They must be brought to realize that responsibility for Grandpa is a shared or co-responsibility, falling to both the home *and* the relatives.

One difficulty of the nursing home which seems to defy solution has to do with finance, and is known to every housewife as the problem of balancing the budget.

Management must somehow purchase at today's high prices such things as food, fuel, nursing care, furniture and linen, and yet be able to keep down its fees so that the home will be within the means of the average income. Fifty or sixty dollars a week, coming from the savings of the aged, is a drain heavy enough to exhaust the funds of even a rich man. Extended illnesses have a way of depleting the pocketbooks of families who finance the care of their older relatives.

Physicians who come into the nursing home on regular calls to patients must be treated courteously by the staff. While we should be alert to lend a hand in whatever way the physician recommends, we must bear in mind that it is the physician alone who treats the patient, and that the nurse's responsibility is to carry out the prescribed orders. The nurse administers medication exactly as she is directed to: the proper quantity, no more, no less; the proper time, no sooner, no later.

Because medical advancement has extended the life of man, it is important that physicians of today be kept interested in geriatrics. More men must be encouraged to enter this specialty field. More studies of the aged must be made and new medicines must be discovered. For after all, Grandpa's well-being depends to a great extent on his being well.

Too often we hear the opinion expressed that old people are "just vegetating"; that they're "useless," so why bother! These "useless" people who are "just vegetating" are human beings, just as you and I are human beings. Their human value doesn't decrease simply because their years increase. Certainly, they are more human than the wise medicine man who writes off Grandpa as a waste of time and treatment.

Legislation, by forcing substandard nursing homes to do such things as install adequate physical apparatus, enrich their menu, and so on, is a measure both praiseworthy and advantageous. Indirectly it elevates the reputation of the nursing profession. It rids our field of cheats and people whose single motive is profit. It keeps the rest of us on our toes. It safeguards the aged.

Government must be sure, however, that its agents who represent the law know thoroughly the nature of the nursing home. An incident which might occur during inspection must not be interpreted as customary or as part of institutional policy. An inspector who is *familiar* with this phase of nursing would understand the unusual incident. In a way, he would know from experience that he could expect the unexpected, whereas, someone new to geriatrics might well be alarmed at many so-called "irregularities."

This is not to say that institutions which drop below lawful standards should not be forced to shut their doors. I am in favor of strict enforcement of regulations, and the immediate, permanent removal from our field of all those who degrade its purpose and offend its patients.

Legislation is indeed protective from the point of view of society, and it does police nursing homes, forcing us to recognize standards and maintain them.

However, we must remember that the law sets the minimum. It prescribes what *must* be done. Its method of regulating is a negative one for it cautions us against treating our patients too poorly.

It will be a sorry day in the history of nursing when the nurse must be watched over by the law. Service to the patient must flow not from the statute book but from the heart of the nurse.

The greatest asset of the nursing home is the love it has for its patients, for where there is love, there is no labor.

Hospital Loses Tax Exemption

SAN FRANCISCO. — In a decision of far-reaching importance to hospitals, the California Supreme Court last month upheld a trial court decision denying exemption from real estate taxes to the Sutter Hospital of Sacramento, a voluntary nonprofit institution. The court found that the hospital failed to meet a provision of the California Revenue and Taxation Code because its operating revenues exceeded operating expenses for the years under consideration; the fact that surplus funds had been used to retire bonded indebtedness and provide expanded hospital facilities was irrelevant, the court held.

"The decision is of tremendous interest to the nonprofit hospitals in this state," Eugene E. Salisbury, executive vice president of the California Hospital Association here, said, "and I think will be of interest to those in other jurisdictions. It is possible that the various states should carefully reexamine their welfare exemption statutes in light of this decision." In a bulletin to members of the California Hospital Association, Mr. Salisbury said the court's decision "has, in effect, denied the benefits intended under the welfare tax exemption law to the nonprofit hospital." "The decision," he added, "established a premium on inefficient management and until reversed or corrected by legislative procedure will adversely affect the tax status of the majority of these institutions."

The hospital brought suit to recover real property taxes paid under protest to the city of Sacramento for the years 1946 and 1947. The trial court found that the hospital did not meet certain conditions stipulated for exemption in the revenue and taxation code; its judgment in favor of the city was appealed to the supreme court.

In a unanimous decision written by Justice Spence, the supreme court referred to a stipulation of the Revenue and Taxation Code providing for tax exemption when "the property is not used or operated for profit, regardless of the purposes to which the profit is devoted." The fact that operating "profits" were used for hospital purposes could not be considered, the court held.

"The determinative factor is the operation of plaintiff's (the hospital's) property for the admitted purpose of producing a profit in the sense that

(*Continued on Page* 160)

NEGROES IN MEDICINE:

A Break-Through Is Taking Place

IN JUNE 1951, THE MODERN HOSPITAL PRESENTED A SPECIAL PORTFOLIO OF articles on hospital care of Negroes in the United States, describing and commenting on different programs in Chicago, New York, Philadelphia, Washington, Evanston, Ill., Gary, Ind., Phoenix, Ariz., and elsewhere. The response to this series of articles was instantaneous, widespread and overwhelmingly favorable to this magazine's positive stand against racial discrimination in the admission and treatment of hospital patients and the appointment of physicians and nurses to hospital staffs.

In the year that has elapsed since these articles appeared, encouraging evidence has emerged indicating increased awareness everywhere that racial discrimination in medical care and medical opportunity is an evil which should be eliminated from American life. Professional journals and general magazines have published articles dealing frankly with the problem. Medical societies and hospital associations have approved resolutions condemning discriminatory practices. Medical schools and hospitals have taken action looking toward improved opportunities for Negro physicians, nurses and patients. As Dr. Franklin C. McLean, University of Chicago physiologist and secretary of National Medical Fellowships, Inc., has said: "We have been recording progress; there is no doubt in my mind that a major break-through is taking place—not all at once or everywhere, but there is a break-through."

In the following pages, The MODERN HOSPITAL presents several progress reports of the break-through, and discussions of problems which remain to be solved. As we said a year ago, doctors and hospitals are not primarily to blame for discrimination in medicine, which reflects discrimination in education, housing, employment and other aspects of our society—but doctors and hospitals can take positive action to eliminate discrimination in medicine when they have the will to do so. It is easy for them to turn aside from injustice and say, "This is no affair of ours," and it is always difficult and often painful for them to act against injustice in an indifferent world. But doctors and hospital administrators who do act to end discrimination in medicine are defending American democracy in the soundest possible way—by strengthening its integrity. They are also preserving for the healing art a priceless heritage which has been diminished by the materialistic attrition of our time—the charitable spirit in which it was founded, as exemplified in the beautiful parable of the Good Samaritan.

—R. M. CUNNINGHAM JR.

NEGROES IN MEDICINE:

Progress in Chicago

OPPORTUNITIES and goals in medicine never before open to Negroes are now attainable. The barriers of segregation are breaking down, and Negroes are found in increasing numbers on the medical staffs of hospitals, as students in unsegregated medical schools, and on their faculties. To document this we made a sample study in Chicago, and are now extending it to other cities. Of Chicago's 61 approved hospitals (excluding Provident Hospital, which is mainly Negro as to staff and clientele) 44 returned the questionnaires indicating the number of Negroes on their medical staffs.

We found that at present there are in effect more than 35 appointments of Negroes to the staffs of the following 11 hospitals, including one hospital which has Negroes on its staff but does not record the actual number: Chicago Municipal Tuberculosis Sanitarium, Children's Memorial, Cook County, Kenner, Lewis Memorial Maternity, Michael Reese, Mount Sinai, Roosevelt Memorial, University of Chicago Clinics, University of Illinois Research and Educational Hospitals, and Walther Memorial Hospital. Three of these appointments are interns, 10 are residents, and the rest are considered "other medical staff."

This represents some progress when compared to the situation prevailing a few years ago. At that time only one or two Negroes had appointments of any kind at one or two of the unsegregated hospitals in the city. It must be pointed out, however, that the picture is not as bright as it appears at first glance. Of the approximately 35 appointments most are to the resident or clinic staffs, and only perhaps seven or eight of these physicians are actually in a position to have their patients admitted on an equal basis to an unsegregated hospital — and of these, not all are considered in the Class A category.

Yet this represents a trend which is apparent in other parts of the country. Within recent years Negroes have been appointed to hospital staffs in all of the United States, including the South.

In Pine Bluff, Ark., two Negro phy-

FRANKLIN C. McLEAN, M.D. **HILDA REITZES**
MAJ. N. O. CALLOWAY

The authors are Secretary and Treasurer, Fellowship Secretary, and Executive Director, Respectively, of National Medical Fellowships, Inc., Successor Organization to Provident Medical Associates, Chicago

sicians were elected last June to the staff of Davis Hospital.

The Memorial Hospital in Phoenix, Ariz., is a completely integrated institution.

Recently Mount Sinai Hospital, at Miami Beach, Fla., announced the appointment of a Negro physician to its medical staff.

The University of Arkansas, which now has Negro students in its medical school, expects to appoint one to an internship at the University Hospital.

At the Methodist Hospital in Gary, Ind., the executive committee of the medical staff passed a resolution that physicians be selected on the basis of professional qualifications and ability without regard to race, creed and color; at present there are seven Negro physicians on its medical staff.

The Gallinger Municipal Hospital in Washington, D.C., has appointed Negroes to its medical staff, and cooperates with Howard University and Freedmen's Hospital in the training of physicians.

In New York City the Montefiore Hospital and Presbyterian Hospital have had a relatively large number of Negro interns and residents on their staffs, and there has been no serious instance of dissatisfaction.

The appointment in recent years of Negro residents to the Hospital of the University of Pennsylvania is another step forward in the breakthrough taking place. Of the 59 internship appointments received by the class of 1952 of Howard University College of Medicine, 33 are in 14 unsegregated hospitals.

IT USED TO BE MUCH WORSE

The over-all improvement in the status of Negroes in medicine can be visualized against the less favorable background of a few years ago, and this also will point out the deficiencies which remain to be made up. As recently as the end of World War II there were only a few hospitals in the United States where Negro and white physicians worked together on equal terms. Harlem Hospital and Sydenham Hospital, both in New York City, were among these few. By far the large majority of Negro doctors were offered internships and residencies in segregated hospitals only. Out of a total of 10,000 internships, Negro graduates in medicine were filling appointments to fewer than 200, with more than half of them in segregated hospitals. Of 12,000 residency appointments on hospital staffs, by means of which the specialists of the medical profession are trained, slightly more than 100 were held by Negroes, with three-fourths of them in segregated hospitals.

Few Negroes held positions on the attending staffs of any but all-Negro hospitals. Since a physician must be on a hospital's staff in order to have his patients admitted, the Negro physicians either took their patients to Negro hospitals, or turned them over to white physicians, who could, in many instances, obtain their admission to hospitals to which the colored physicians had no access. Undoubtedly the shortage of well trained Negro physicians was in part responsible for the relatively small number of medical appointments to unsegregated hospitals, since recently several administrators of hospitals and medical schools have stated that now they are willing to accept Negroes, and not nearly enough possess the technical qualifications.

As pointed out in the beginning, today there are unmistakable signs that the pattern of isolation and segregation is breaking up — not everywhere or all at once, but in enough places, sufficiently widely distributed, to make it easier for many Negro physicians and their patients.

The most important developments are taking place in the nation's medical schools. Within recent years nine Southern universities have enrolled Negro students in their medical schools, and unsegregated medical schools, particularly in the North are now, for the first time, reaching out for qualified Negro students.

The following enrollment statistics illustrate the gradual acceptance of Negro students in medical schools: There were 45 Negro medical students in 1938, and in 1947-48, out of a total of 25,000 medical students, 85 Negroes were enrolled in 20 unsegregated institutions. In 1948-49 there were 117, in 1950-51 there were 143, and in 1951-52 about 175 Negroes are attending 48 unsegregated schools — an increase of almost 400 per cent since 1938.

This development is of great significance. For as these students advance in their training, many will naturally take part in the clinical programs of their institutions, and later obtain junior staff appointments. And it is here that the Negro physician must begin his affiliation with an unsegregated hospital in order to compete on equal terms with his colleagues for advancement to senior staff positions.

In 1950-51 the five Chicago medical schools had a total enrollment of 2082 and of these 13 were Negroes. For the 1951-52 school year there are 19 Negroes enrolled; two each at the Chicago Medical School and the University of Chicago, nine at the University of Illinois, and three each at Northwestern University and Loyola University. The number of Negroes enrolled in the Chicago medical schools seems small when compared to the total enrollment of the schools, yet it represents more than 10 per cent of all Negroes enrolled in unsegregated medical schools in the United States. Increasingly, Negroes are being admitted to Chicago medical schools without discrimination as to race, and properly qualified applicants are receiving the same consideration as members of other races. And the number of Negroes with such qualifications is expected to grow as facilities for their basic education are augmented and improved.

PROPORTION IS UNCHANGED

While the quality of the medical education available to Negroes is steadily improving, the proportion of Negro physicians to Negro population remains unchanged. In 1930 the Negro's representation in the medical profession for the whole country and in proportion to the numbers in the total population was less than one-fourth of that of the white's. In 1950 there were about 4000 Negro physicians and surgeons out of a total of 209,040 for the United States — a ratio of one physician for every 720 people in the United States, but only one Negro physician to each 3500 Negroes.

In Chicago the ratio of Negro physicians to Negro population is approximately one to 2000, while for the general population it is one to 484. In only two cities in the country does the ratio of Negro doctors to Negro population approach the general ratio: St. Louis, and Washington, D. C. To maintain a minimal standard of medical service it is accepted that there should be one physician to 1500 population. In Mississippi the ratio of Negro doctors to Negro population

is one to 18,527. Although Chicago has in both white and Negro physicians a ratio well above that of the national mean, nearly 30 times as many white as Negro physicians are in practice, while the white population is only seven times that of the Negro.

The citing of these data, however, should not be taken to mean that Negro physicians do or should have only Negro patients, or that Negro patients necessarily should be cared for by Negro physicians, but rather only to indicate that Negroes have not enjoyed equitable opportunities in medicine. This has an adverse effect upon the practice of medicine among the Negro population, since the quality of the medical service available to Negroes is directly related to the quality of the Negro medical profession.

As pointed out, an increasing number of Negro medical students are now being admitted to unsegregated schools, yet the supply of Negro physicians largely depends upon the graduates of the two Negro medical schools, Meharry in Nashville, Tenn., and Howard in Washington, D.C. In 1938-39, 87 per cent of all Negro graduates in medicine were from these two schools, and as of the June 1952 graduates 80 per cent are enrolled at Howard and Meharry. There is still a great gap in the medical school enrollment of Negroes as compared to the general enrollment. If Negroes were enrolled in medicine in the proportions in which they are present in the population, there would be approximately 2600 in training, instead of the 700 as at present, including the segregated schools. Thus, although there is an increase, the need is far from being met.

Because in the past the Negro doctor has had limited opportunities, and for economic reasons as well, he was on the average less well trained than the white doctor. However, as indicated, the quality of medical education available to Negroes is rapidly improving and there are now many excellent training opportunities open to Negroes. Of the 33,000 certified medical specialists in the United States, approximately 190 are Negroes. In 1949 there were 101 Negro specialists, and in 1947 there were about 93.

As the stature of Negroes in the medical profession grows, they are gaining recognition by the special medical societies. A few years back, the American College of Physicians had no Negro members; now it lists six fellows and six associate members. The same is true for the American College of Surgeons. Five years ago it had no Negro membership, in 1949 there were 18 Negro fellows, and by now 60 Negroes have become fellows of the college. The same trend is apparent in the membership rolls of most other medical specialty societies.

Corresponding to the expanding opportunities for Negro physicians in unsegregated hospitals, there have been comparable increases in the number of Negroes on the faculties of the nation's medical schools. In Chicago there are at present 19 such appointments: seven at Chicago Medical School and seven at the University of Illinois College of Medicine, two at the University of Chicago School of Medicine and two at Loyola University Stritch School of Medicine, and one at Northwestern University Medical School.

As demonstrated above, important developments are taking place to equalize opportunities for Negroes in medicine. Thus there is the prospect of a stronger medical profession, better able, both qualitatively and quantitatively, to meet the need which so clearly exists.

Report From New York

LOUIS T. WRIGHT, M.D.
Harlem Hospital
New York City

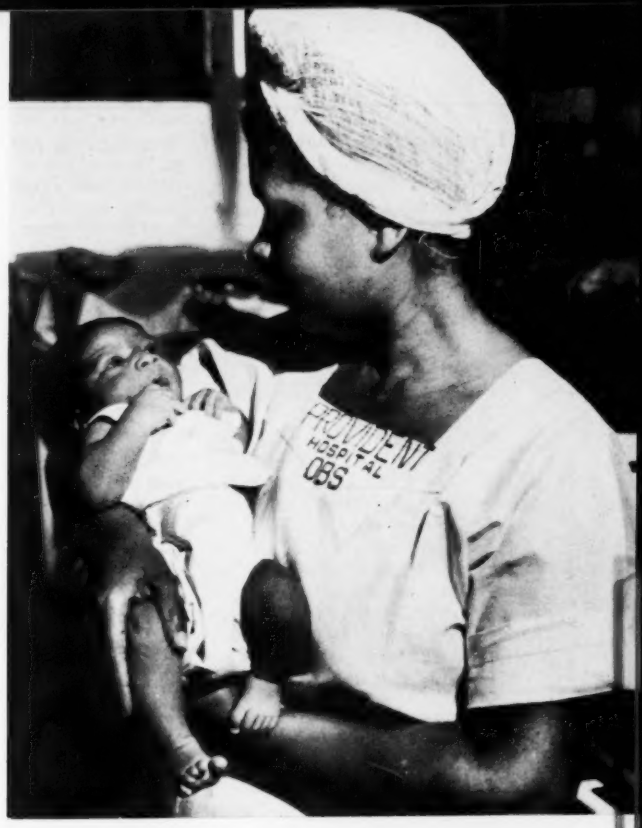
HARLEM Hospital represents, to my mind, the finest example of democracy at work in the field of medicine. Its policy of complete integration throughout the institution has stood the test of time, having now been in practice more than 20 years. There is no racial or national bias, no segregation. Merit alone—in the light of the highest standards—governs the selection of professional personnel. Patients of all races are admitted and treated by doctors of many races. The nonprofessional personnel of the hospital operates on the same basis and the nursing school, where the students are colored, would welcome student nurses of other racial groups.

The patients who come to Harlem Hospital are largely indigent persons without the means to go elsewhere for diagnosis and treatment. Our doctors, dedicated to the proposition that these patients should have the best medical care possible, have worked ceaselessly and untiringly toward that goal. In so doing, our standing in the medical profession has been enhanced and, I hope, that of the profession itself.

The hospital has met effectively and efficiently day-to-day responsibilities of an especially grave nature. No one can any longer question the wisdom of total integration in the operation of large institutions. It has served as a basis of ennobling growth and strength for all of us. We are proud of the record of this hospital as an instrument of democracy because it carries out the ideal of the brotherhood of man and respect for the dignity of all persons.

I wish to pay tribute to former commissioner, Edward M. Bernecker, who did much to remove racial restrictions from the New York City Department of Hospitals, and to our present commissioner, Marcus D. Kogel, who has expanded enormously the application of this concept. Many distinguished surgeons of New York City have assisted the surgical department of Harlem Hospital.

Dr. Henry W. Cave, former president of the American College of Surgeons, was the leader in the successful effort to eliminate racial bias so far as concerned the admission of qualified Negro surgeons to the college. Membership in this distinguished body gives an opportunity to all members of the profession to improve themselves and to keep abreast of the best surgical procedures. Through this elevation of professional standards, the lives of many patients throughout the country, as well as in Harlem, have been saved.



Under conditions described by Dr. Raines, this baby has a poorer chance to live and stay well than white babies have—and an uphill battle all the way if he should want to study medicine when he grows up.

NEGROES IN MEDICINE:

Barriers to Community Health

TAFT RAINES, M.D.
President, Medical Staff
Provident Hospital
Chicago

BEFORE the year 1910 the medical care given to sick people in this country was at a low ebb. As a result of the conditions existing at that time, the Carnegie Foundation sponsored a study of medical education. In the course of this work a critical survey of the medical schools of this period was made. Gross inadequacies were found. Among other things, there were very few medical schools which had provisions for bedside training.

When finally published, the Flexner report virtually revolutionized medical training and practice. The present high-grade medical care which most of the people in this nation enjoy had its genesis in this change. The rapid strides that have been made in biochemistry, physiology and surgery, the introduction of highly effective but potent drugs requiring accurate laboratory controls, together with many other factors, make it almost impossible for a physician to practice modern medicine without the facilities of a hospital. The physician-hospital relationship which, a few years ago, was considered a luxury is now considered vital for better community health.

This fact has been recognized in cities throughout the country. In New York City, the Hospital Council of Greater New York, working on the premise "that it would be in the interest of improving standards of medical care received by the people of the city of New York if every physician in active practice had the opportunity of working in hospital wards and outpatient departments and of attending his own patients in private and semi-private accommodations" made the following recommendations:

"1. That hospitals make available to physicians in active practice the opportunity to serve in ward and outpatient departments and to care for their own patients in private and semi-private facilities.

"2. That, wherever feasible, voluntary hospitals afford all members of their staffs a combined appointment, *i.e.* the privilege of working in their wards and outpatient departments and of caring for private patients.

"3. That hospitals provide supplementary appointments for physicians who have incomplete appointments at other hospitals, namely, physicians with ward or outpatient connections only at municipal or voluntary hospitals and those with private patient privileges only at proprietary or voluntary hospitals.

"4. That all hospitals appoint general practitioners to their staffs, and, under the jurisdiction of the chiefs of the various services, give them the opportunity of working in different departments, the privilege of private patients, and the educational advantages afforded by the institution; and that general hospitals establish appropriate professional units to guide the activities of general practitioners on their staffs, and to work out a program for each individual practitioner with the various clinical departments.

"5. That all hospitals make available opportunities for staff appointments in ward and outpatient services and private patient privileges for Negro physicians for whom these op-

Condensed from an address presented at the Fourth Conference on Civic Unity, sponsored by the Chicago Commission on Human Relations, May 1952.

If you want to make the world better, begin with yourself.

—St. Ignatius Loyola

portunities are now limited. Hospitals exclusively for the use of Negro physicians are not recommended.

"6. That hospitals review periodically their medical staff positions and, whenever possible, provide staff opportunities for physicians without hospital appointments."

The question of the organic structure of medical staffs is an interesting field in itself and might well be the subject of a prolonged discussion, but suffice it to say that the courtesy staff arrangement meets a real need. It permits the general practitioner, and in rarer instances the specialist, to maintain a desired relationship with his patient without the factor of competition entering in, which arises when the regular staff position is in question.

RULES SAFEGUARD PATIENTS

In consideration of men for courtesy staff privileges only the welfare of the patient and the humane consideration of a fellow practitioner need to be taken into account, because the rules and regulations of the hospital and the supervision and training program of the medical staff safeguard the interest of all concerned.

The majority of nonwhite physicians are general practitioners, as indeed the majority of white physicians are. The failure to recognize the need of this group is a constant reminder that community health at its grass roots is in danger.

A casual survey of the location of Chicago's various ethnic groups reveals that the former pattern in which minority groups were concentrated in one area has been disturbed. These groups are at present living scattered out over the city.

In the areas where there are large concentrations of the nonwhite populations we find that the present medical facilities are admittedly inadequate. Even these are not available on an equal basis to nonwhite medical men practicing in these areas.

In the hospitals in or near the areas in which there are large concentrations of nonwhites, there is a total bed capacity of approximately 8485. Of this number roughly a third, 2500 beds, are being occupied by nonwhite patients but, for one reason or another, are not accessible to nonwhite physicians. No attempt is made to imply that only nonwhite physicians should care for nonwhite patients, but this analysis does point out a practical problem.

The only accredited institution which is readily accessible to the approximately 250 nonwhite physicians in Chicago is Provident Hospital with a bed capacity of only 208. We take great pride in the fact that even this small number of beds is shared with competent white physicians.

There are those who admit that it is morally right that qualified Negroes be given staff positions in the hospitals in their communities, but they say also that the problem is impossible of solution without serious disruption within the hospitals.

The facts do not support such a view. Only a few years ago, the persistent refusal of even emergency cases by the overwhelming majority of hospitals in the Chicagoland area led to such public indignation that it culminated in an effort to solve the problem by legislation. Since that time, many of the hospitals in this area have gradually lifted the bars without any serious consequences.

I recall that the first few Negro nurses who attended the nurse training school at Cook County Hospital did so only after a very bitter fight. At present not only are Negro nurses in this institution but also they are in several of the private institutions, many of them of national reputation.

Negro residents and interns are now working in several institutions and so far only the usual problems which are general to this group have been encountered.

I would like to quote from a recent report of the United Packinghouse Workers of America, C.I.O. (a union of both whites and nonwhites), in which the problem of medical care in the Chicago area has been studied. It states as follows: "Because of discriminatory practices, our members are deprived of adequate protection under private insurance company policies. . . . The problem is made more serious by the discrimination which exists in Chicago medical institutions. Negro physicians are kept off the staffs of most hospitals and discrimination in various forms is to be found against Negro patients. Our members are, therefore, frequently subjected to inferior medical care and facilities and are deprived of the right to their own physicians.

"Recommendations:

"A. Provide in our new union agreements for a complete, company-financed insurance system, which will pay adequate benefits in case of illness and disability, hospitalization or death, and will provide retirement pensions. Medical care insurance should also be initiated, covering not only surgical fees, but also home and office visits, and medicines for members and their families. Our goal should be a union health center, which will not only provide medical care of a high type, but will also do research in diseases of the packing industry, and carry on health education and prevention programs.

"B. Prohibit the expenditure of public funds in any medical institution which discriminates against Negro physicians, nurses or technicians, or which discriminates in any way in the selection or treatment of patients. Remove their tax-exemption privileges. Demand that Blue Cross refuse to approve hospitals which practice discrimination.

"C. Take steps to initiate a medical center at the U.P.W.A. hall at the earliest feasible time, as a beginning toward a union medical center."

I think that these recommendations speak for themselves. At least in this union, there seems to be a serious concern over the problem we are discussing.

Another objection that is raised by administrators is that the nonwhites will add to the financial burden of institutions which are already overtaxed. This problem is a real one, not only for nonwhites but also for whites who fall in certain economic groups. This brings up one of the liveliest issues of the century—what to do with those patients who wish to maintain the doctor-patient relation and not submit to the prevailing custom in the public institutions where this fundamental relationship is abrogated.

There is no question in my mind that the medical profession and other private agencies can do the job with-

out creating problems which would make the cure worse than the disease. However, the large number of patients who are not covered by prepaid health insurance is still a barrier to adequate community health.

The question is sometimes asked: Why do not Negroes build their own hospitals? "Because of the nature of the financial structure in this country," states the National Fund for Medical Education, Inc. "Philanthropy has always played a big rôle. . . . The possible sources of private philanthropy have changed drastically. The impact of income and inheritance taxes is accountable for much of this change. Medical schools can no longer rely on a few large donations for support. . . . Two great resources of money today are, in one case, the government; in the other, the income earning power of the vast reservoir, under a corporate mantle, of private investments in American enterprise." And what is true of medical schools is certainly true of hospitals.

The future of any nation lies in the youth. These young men who leave the medical schools with an urge to serve, with medical ideals firmly implanted, and devoted to the highest modern medical standards, must not be sacrificed on the altar of blind prejudice. They must be allowed to become a part of the body politic of this nation, so that they may keep their drive and maintain their goals by opportunities to continue growth by constant contact with local medical centers. This can only be accomplished by appointments to staff positions at hospitals. The more desirable men will not accept second-rate status.

It will be a happy day when the question of black and white no longer interferes with the democratic way of life, when hospitals are open to any sick man who needs treatment, when colleges and universities give universal education to all, and when the ideal so vociferously declared becomes a reality.

In essence, all these problems reduce to just two: (1) That of doing justice to a minority group, and (2) that of securing the best interests of all. The American people would like to do both, of course. Is it possible to do both at the same time, or must they sacrifice one to accomplish the other? This is the real question that future citizens must face.

There are some who deem it necessary to deny the rights of the minority, to limit their opportunities, and "keep them down" in order to advance the welfare of the majority.

There are others who feel sure that no good can come from injustice, that in keeping others down people degrade themselves, and that the best interests of all will be served by the highest welfare of each.

The former view is the theory of autocracy against which our Revolutionary forefathers revolted. The latter is the theory of the democracy which they established. Which shall America follow in reference to its 15,000,000 Negro citizens?

One of the major barriers to adequate community health is the color bar which most of the hospitals in and about the nonwhite communities have as a policy in staff appointments. This is true because the community's health is directly proportional to the degree of training and the facilities for a continuing program of training that are available to the physician in a community. At this time the focal point of training is the hospital's medical staff.

This problem can be solved when medical men, recognizing their public responsibility, decide on a constructive course of action. It is encouraging to note that many outstanding physicians are beginning to give serious thought and lend substantial support to this proposition. It should be recognized, however, that since the governing board of a hospital consists of public spirited citizens whose concern is public health, these men and women cannot logically close their eyes to this problem.

Council Urges Hospitals, Physicians to Act

HOSPITALS, medical schools and the medical profession have made encouraging progress in recent years in extending their facilities to members of minority groups. The intake policies to inpatient and outpatient facilities have been substantially liberalized; professional personnel from minority groups has been added to hospital staffs in such classifications as nursing, medical social work, and laboratory and x-ray technicians; schools of nursing have begun to accept Negro student nurses; in a few instances Negro physicians have been added to hospital staffs.

The health division of the Welfare Council of Metropolitan Chicago as the central planning and coordinating facility for the community is concerned that health and medical services should be available to people in need without reference to race, color or creed. The health and medical field, we believe, should lead in setting an example for the community in services to people only on the basis of their needs. Accordingly the health division proposes the following principles for consideration by all concerned:

1. It should be the goal of all hospitals, voluntary and public, to serve all people in need of medical care without regard to race, color or creed.

2. All hospitals should encourage in every way possible appointments of qualified physicians to the appropriate classifications of the hospital medical staff without reference to race, sex, color or creed.

3. In consideration of the normal procedure of medical staff appointment and advancement, hospitals should direct special attention to appointments of qualified interns and residents from minority groups.

The executive committee of the health division commends the foregoing principles to hospitals and physicians and urges that they should continue to consider through their respective associations the most effective ways for implementing the foregoing principles.

NEGROES IN MEDICINE:

Round Table on Current Problems

A FEATURE of the Fourth Conference on Civic Unity sponsored by the Chicago Commission on Human Relations was a round table discussion on current problems of discrimination in medical and nursing education, appointments to hospital staffs, and admission and treatment of hospital patients. Believing this discussion would be of interest to readers, The MODERN HOSPITAL obtained a transcript which is presented here in condensed form. Taking part in the discussion were: Dr. Frederick J. Mullin, dean, Chicago Medical School; Dr. A. L. Baralt Jr., dean, Loyola University School of Dentistry; Dr. Donald Anderson, secretary, Council on Medical Education and Hospitals of the American Medical Association; Rt. Rev. Msgr. John W. Barrett, archdiocesan director of hospitals, Archdiocese of Chicago; Maj. N. O. Calloway, assistant chief of medicine, Percy Jones General Hospital, Battle Creek, Mich.; Mrs. Esther Buccieri, Illinois State Nurses' Association; Dr. Taft Raines, president of the medical staff, Provident Hospital, Chicago, and Dr. Franklin C. McLean, secretary, National Medical Fellowships, Inc., Chicago. Robert M. Cunningham Jr., editor of The MODERN HOSPITAL, acted as moderator for the discussion.

MR. CUNNINGHAM: Five or six years ago, the Commission on Human Relations made the recommendation that medical schools should eliminate considerations of race, religion or national origin of applicants in making selection for entrance, and that all inquiries concerning race, religion or national origin be deleted from the application blanks, and that character and personality traits and integrity should continue to be heavily weighed in the consideration of applicants. Race or religion should not be factors in appraising these qualities. Dr. Mullin, as the operating head of a medical school, how well do you think that those recommendations have been achieved?

DR. MULLIN: I think they have been achieved very well. I think that there are many more problems about the selection of medical students than most people realize.

There is, of course, first the problem of actual academic qualifications. There are many problems in relation to attitudes, such as honesty, sincerity, service and others as well, that we have to seek in applicants. Many of the medical schools that formerly did have some other restrictions have now removed these restrictions. I think it is clear that there is no significant barrier to Negro applicants to medical schools in this country today. There are places available for all qualified Negro applicants.

There is, of course, the problem of previous education, and I believe it is in that area that Negroes have not been given equal opportunities with others.

The function of an admission committee of a medical school actually, of course, is to select from a number of applicants those who are best qualified. This committee must discriminate, but it must not use for discrimination either race, religion or national origin. It must use the personal integrity and the individual characteristics of the applicants. If it does that, and I am sure that most committees do, then the best interests of society will be served. I believe all our medical schools here in the city do judge on the basis of individual qualifications for the admission of applicants.

MR. CUNNINGHAM: Dr. Baralt, you are also an educator, and I ask you if you think that this recommendation has been achieved as well in your field as Dr. Mullin has reported it has been achieved in his?

DR. BARALT: I would almost have to bring out the same points that were brought out by Dr. Mullin. I think there have been great strides in the dental schools as well as in the medical schools. I have been connected with two dental schools in my short time in education, and in both of them there has been no discrimination whatsoever on the part of the admission committee in the acceptance of nonwhite or Jewish applicants.

The biggest problem has been one of receiving qualified applicants. I can point to our own statistics in the particular school that I represent. Of 400 completed applications we had three from Negroes. One of them was rejected on the basis of no aptitude in working with his hands, the second on the basis that his records were not complete. The third one we were very happy to accept as our student, and we are looking forward to his coming next year.

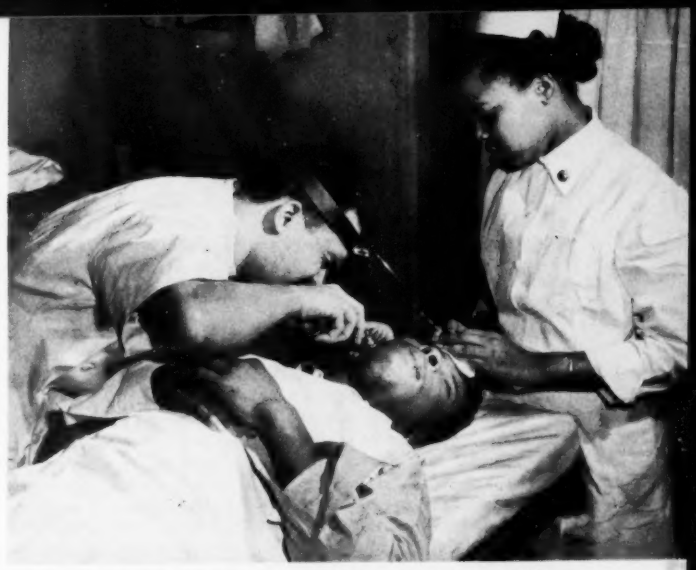
I am all in favor of eliminating from consideration the subjects of race, religion and national origin; however, I question that we can do it by deleting the picture from the application blank, as some groups insist we should do.

MR. CUNNINGHAM: Dr. Mullin, you didn't mention in your comments the particular point about application questions having to do with race and religion. Do you think it is a waste of time to discuss the elimination of those phases of the application blank?

DR. MULLIN: I don't think it is a waste of time to discuss such problems. Neither of the two schools that I have been associated with have such applications. I think such questions have been eliminated from a great many medical schools. In the final analysis it is the integrity of the admission committee of the school that determines the policy.

All our Chicago medical schools now do have Negro medical students, and I believe that this matter of pictures is often very helpful. Many times in dealing with large groups, where interviews have taken place, a picture may be useful as the means of refreshing the memory of the committee; in some cases it may actually prevent unfair discrimination. Certainly the picture should not be used for means of discrimination.

MR. CUNNINGHAM: I have heard that in Chicago medical schools there is apparently a predominantly Jewish enrollment at one school, a predominantly Catholic enrollment in a Catholic school and predominantly Protestant enrollments in Protestant schools. Do you believe that is significant?



Care of Negroes by Negroes in all-Negro hospitals is stultifying for nurses and doctors, bad for patients, most authorities claim.

THERE IS NO QUOTA HERE

DR. MULLIN: I can only speak for one school. The majority of our applicants, as well as our students, are Jewish. We have no discrimination on racial or religious grounds in any sense; the fact that we have a majority of Jewish students is due to the fact that the majority of applicants are Jewish. There is no quota. I cannot speak for any other school, although it is my feeling that most of the schools admit applicants on the basis of ability.

DR. BARALT: I think we have a similar pattern at all our schools. Loyola University being Catholic, I think it is only natural to assume that the majority of our applications are from Catholic students. I would say that roughly 65 per cent of our present students are Catholic.

MSGR. BARRETT: I would like to point out that the various sectarian groups, including the Catholic Church, maintain educational institutions because of religious convictions and the belief that religious education is a part of education in the preparation for life. It therefore follows that the largest number of applicants in any sectarian group or to a sectarian university certainly would be of that religious faith. With reference to Loyola University, I think you will find a high percentage of Catholic students. That also applies to all the individual schools within the university. However, I know that the Loyola University School of Medicine is ever ready to admit nonwhite applicants who are qualified.

With reference to the picture and the question of race and religion on the application: I think, particularly with reference to a Negro applicant, that it would work in his or her favor to have that information.

DR. ANDERSON: It is my distinct impression as I go about the country visiting the various medical schools, except in those states where there is still segregated education, that the Negro applicant for medical school enjoys an advantage over others. It is the concern of the medical schools to find and train well qualified Negroes as such, and I base that on my numerous conversations with the officials of medical schools and also the chairmen and members of admission committees. If you found two men with equal qualifications today, and one was white and the other a Negro, I would say that the odds in most of the northern schools would certainly be in favor of the Negro applicant. I might further say that once those men get into your medical schools, more effort is made to help them with any difficulties they may encounter than is done with the bulk of the student body.

I would like to mention this matter of the picture on the application. In my discussions with the members of the admission committees I find that they have become very restless and at times quite irritated at the pressure in certain areas to have them remove this identifying characteristic from the application blank. They find the picture of great value to them in recalling the individual candidate when they review his application.

PHOTOGRAPH GIVES A CLUE

When a man sends along his photograph with an application to a medical school and he sends the picture showing himself in a sport shirt or bathing suit, you immediately wonder about his judgment in certain matters; whereas, if a candidate sends in a sober and dignified picture you get a neutral impression. I can assure you that this is a very minor thing, and that applicants are not selected on that basis alone, but it does add to the impression. I hope that some of the pressure to have the photographs dropped will be removed. It would bring about a much better understanding on all sides of this problem.

MAJOR CALLOWAY: I have heard this battle fought back and forth, and as a member of a minority group I would like to take issue as to the picture on the application blank. I can't see that any useful purpose can be served by having it there.

I also cannot agree that any medical school has any right to draw a line on account of religion, whether it be

(*Continued on Page* 134)

NEGROES IN MEDICINE:

Washington Proposal for Self-Help

REV. AMOS H. CARNEGIE
President
National Hospital Foundation, Inc.
Washington, D.C.

THE time has come for us to face our problems squarely and devise a plan to solve them; to acknowledge the existence of pressing social needs among us, which we ourselves must take the initiative and assume the responsibility of meeting, and meet them; to recognize unhappy conditions that confront us as a group, and as a group put forth every effort to correct them. I trust that after we shall have discussed these problems and needs and unhappy conditions, we shall adopt the plan which we are proposing to solve the problems, to meet the needs and to correct the unhappy conditions.

MUST DIAGNOSE THEIR STATUS

In order for a doctor to treat a patient successfully he has first of all to diagnose his case to find out what the patient is suffering from, and to treat him for that ailment. Thus only will the patient recover from his illness. In order to improve our condition as a large minority group in a majority civilization, we must diagnose our status and see just where we stand and how we look in comparison with others in a common community, and see whether or not we are satisfied with our condition, or with our status, as the diagnosis reveals it. I have tried to diagnose our status as a large minority group in a great majority civilization, and I have discovered that our status is very unhealthy and that we cannot continue any longer without doing great damage to ourselves and to the community and to the civilization of which we are a part. I have discovered the following ailments:

We are absolutely dependent on our white neighbors for everything. There is no phase of our existence in which we show any sign of independence except, perhaps, in our religious life, where we worship God according to the dictates of our own conscience in our own churches. So it is only in our church life that I find independence. Fifteen million of us depend almost altogether on the white people for jobs, a condition which robs us of our independence in thought and word and deed. We can hardly think as we please and speak as we please and act as we please because the people from whom we get jobs hold over our heads a big economic club and make us think as they want us to think, and speak as they want us to speak, and act as they want us to act. This is almost a state of servitude, and we have got to find a way to redeem ourselves, at least in some respects, from this servitude.

You will be surprised to know the effect that this servitude has on the thinking of our leadership. It makes it fail to act in the light of its own judgment, feeling such action might offend those from whom we earn our bread, and, on many occasions, causes which we should support with all our hearts we fail to support lest, by such support, we should offend those from whom we earn our bread. This is a very unhappy condition, and we must, in a measure, redeem ourselves from it.

A second ailment is that though our white neighbors have been very kindhearted in helping us to develop so great an economic advancement, we nevertheless are a great burden to them. They have been carrying us along for nearly 100 years, and they are feeling everywhere that the time has come for us to begin to do something for ourselves, to stand on our own two feet, and carry our own weight and relieve them of some of our burdens. Indeed, we are getting very heavy for them to carry, because the more we develop intellectually the more we demand opportunities for the expression of our intelligence, which openings are not available, and they are beginning to feel that we should, as a group—15,000,000 strong—begin to create some of those opportunities for ourselves.

"THE BURDEN IS TOO GREAT"

In the matter of hospitals all but two of the hospitals of the city of Washington are private, established and maintained with private capital. These private hospitals feel, as others feel all over the country, that the burden of caring for so large a minority group is too great. They feel that they have enough burdens to care for their own people, let alone caring for others. Hospitalization is a social service, and white people are not inclined to minister to us in a social manner. In fact, they do not care to serve us in any of their social institutions. They do not care to serve us in their hospitals, in their hotels, in their restaurants, or in any of their social institutions, and we cannot make them. We cannot change them overnight; we cannot make them over. We should begin to create and maintain our own social institutions, and render services to our people, which is our bounden duty.

Another trouble is that our group is becoming more and more intelligent day by day, and we are needing openings, opportunities for advancement, which do not exist. It is our duty to create them. For instance, during the past year the high schools, colleges and universities of this country graduated 600,000 youngsters, all of whom are out seeking jobs. Sixty thousand of these youngsters are Ne-

groes, and they all have to knock at the white man's door for openings. This is too great a burden on him. We should have some doors of our own on which our youngsters can knock for openings—not only *our* youngsters, for I believe that, while we have been knocking on other people's doors all these years, we should have some doors, too, on which all youngsters might knock.

START BY WANTING A CHANGE

Now you ask me: "What is your solution?" The solution rests, first of all, in a desire for improvement. We cannot bring about a change unless we are willing for it. Are we willing and are we ready for the improvement of our condition? If we are, we have a plan that has taken us years to develop; a plan that the nation's leaders of both races have endorsed; a plan that can bring about a great change in our social and economic life, which may be brought about so easily and so simply and so painlessly that we shall not even realize that we are doing it. All that is required to make this plan work, and work quickly and miraculously, is a little cooperation on the part of all of us.

Let me say to begin with that this is not a plan for any local community, or rather, that it is not a plan that can be carried out in any local community by itself. There is not a community in the United States of Atherica where there are 10,000 or more of us—not even in Washington, where we possess more per capita wealth than in any other community in the United States—that we can establish and maintain a modern hospital. We have got to do it together—15,000,000 strong. It is a people's movement. It is a mass movement, a movement that embraces all of us, and it is only as we come together and work together like the fingers of the hand that we are going to be able to make this plan work.

This is the plan. We are asking every Negro in the United States—15,000,000 strong—beginning in Washington, to join the movement which we have created, known as National Hospital Foundation, Inc., and pay a membership fee of an average of $1 a year. We have four types of membership: a one-year membership for $1; a five-year membership for $5; a 10 year membership for $10; and a life membership for $50. But we are stressing the one-year membership, because we want to put it within the reach of everyone. These memberships are to be collected through our churches under the direction of our ministers, who are our recognized leaders, each of whom is being asked to be the captain of his own congregation and a joint leader of the movement in his church and community.

It is the aim of the foundation to establish the first $4,000,000, 200 bed interracial hospital and nurses' home here in the nation's capital where there is an acute need, as of now, for 1900 additional hospital beds for our group. Toward this amount there is a bill before the Congress (H.R. 1209), introduced by the Hon. John L. McMillan, chairman of the District of Columbia committee, to get us a grant of $2,000,000, and toward which a wealthy local lawyer, Rudolph B. Behrend, has donated an excellent site which is worth $250,000 to us, on East Capitol Street and Texas Avenue, on which to erect this proposed hospital.

Now, we are to raise $2,000,000, and the federal grant of $2,000,000 will be made after we have raised our $2,000,000. So now it is up to us! Do we want to see a first-class, 200 bed hospital, second-to-none in the country, established in Washington, to be owned and controlled by us in which we shall demonstrate the practice of democracy and Christianity? Do we want to experience the thrill of having a hospital of our own, in which our people will always find welcome, and where the most modern service can be rendered to the sick? If we do, then it is up to us to take hold of this simple plan and put it over the top in a big way and in the shortest time possible.

NOT NEGRO HOSPITALS—BUT HOSPITALS

THERE are some people who hold the mistaken idea that because the National Hospital Foundation, Inc., is a movement sponsored by the Negro people, it is therefore going to establish Negro hospitals. The foundation does not intend to do any such thing; it is going to establish hospitals, period.

The National Hospital Foundation, Inc., aims to assist in providing the Negroes' proportionate share of the hospital beds needed to meet the health requirements of the communities where they compose a large segment of the population, as they do in New York, Chicago, Philadelphia, Detroit, Washington, Los Angeles, San Francisco, Baltimore, and St. Louis, where the Negro population ranges from 200,000 to 800,000, and not only where the hospitalization of such a large minority group is a burden on the voluntary hospitals of these communities, but also where lack of adequate hospitalization is reflected in the lowering of the health standards of the communities.

The hospitals of the foundation will be integrated with the other voluntary hospitals of the communities where they are established and will serve all the people, regardless of race, creed, caste or color. Their staffs will be open to every physician in the community who is a graduate of an accredited medical school and who is a member in good standing in the local medical society.

The National Hospital Foundation, Inc., aims to redeem the Negro people from the embarrassing situation of having to depend almost wholly on others for hospitalization, and from having to be transferred from the hands of their own Negro physicians to other physicians, because their Negro physicians cannot follow them into hospitals where they have no staff membership. And it aims to redeem the Negro physicians, too, from the embarrassing and humiliating experience of having to surrender their private patients to other physicians, when they need hospitalization, not because they are incapable of ministering to them, but because they are denied the privilege of ministering to them in hospitals.

The foundation, however, is not complaining about this existing problem; it is as natural a situation as it can be, human nature being what it is. Rather, we are seizing an opportunity to provide the Negroes' proportionate share of the hospital beds needed to meet the requirements of the communities where they compose a large segment of the population.—AMOS H. CARNEGIE.

NEGROES IN MEDICINE:

Practices and Attitudes in Southern Hospitals

JAMES A. DOMBROWSKI
Director, Southern Conference Educational Fund, Inc., New Orleans

WHAT is the lot of the Southern Negro who needs hospital treatment? What are the attitudes of that region's hospital administrators toward racial problems as they affect medical care?

In an effort to gain at least a partial answer to these questions, the Southern Conference Educational Fund recently polled the administrators of the 2414 institutions which the American Hospital Association Directory lists for 18 Southern and border states and the District of Columbia.

They were asked (1) if Negroes were admitted to their hospitals as patients and as doctors; (2) what distribution of beds was made between white and Negro patients; (3) what racial policy did they think best served the health needs of their communities.

SEGREGATION WIDESPREAD

Usable replies were received from 711 institutions—a return of 29.2 per cent. The ballots—as could be expected—reflected widespread segregation practices. And the statistics they afforded point out some of the ironies and inequities segregation entails.

For example, 584 of these hospitals (82 per cent) admit Negroes as patients. But, of a grand total of 102,969 beds in 676 institutions (35 federal and specialized establishments were exempted from this calculation), only 33,451 beds (32.4 per cent) are available to Negroes.

It is unrealistic to argue that this 32.4 per cent allotted Negroes closely follows census figures for the region and therefore should suffice. Illness and accident obey no such norm. Furthermore, the Negro's generally depressed economic status tends to increase his need for hospitalization.

Yet 406 hospitals—with more than two-thirds of the space for Negroes—admit them on a strictly segregated, quota basis. There is a Negro ward, and once it is filled, no more are admitted no matter how vacant the white sectors of the hospital may be.

In addition to this artificially erected barrier, it should also be noted that in several states, Louisiana and South Carolina particularly, Negro hospital space is concentrated in one or two large institutions. The inconvenience and health hazards suffered by persons living in distant areas can be imagined.

About the brightest part of the picture is the existence in the South of 108 hospitals (exclusive of federal and all-Negro institutions) where color does not determine accessibility of care. In 68 of these, neither segregation nor a quota limit governs use of bed space. Forty more practice segregation but allot beds according to need.

What do the administrators think about this state of affairs?

In a section of the questionnaire asking them what racial policy "best serves the health needs of the entire community" three alternate plans were offered them: Plan A, favoring the admission of Negroes without segregation; Plan B, favoring admission with segregation, and Plan C, favoring the maintenance of separate hospitals for Negroes and whites.

In general, the administrators voted for the status quo prevailing at their respective institutions. Plan A received 125 votes (17.6 per cent); Plan B, 439 (61.7 per cent); Plan C, 76 (10.7 per cent); 71 (10 per cent) did not answer the question, or favored other proposals.

The comments offered by the various administrators perhaps may serve to "flesh out" these figures. Those included in this article are not to be considered necessarily typical but were chosen for the attitude expressed or condition described.

"I am in favor of no segregation," said the administrator of a small hospital in Kentucky. "From what I have seen I think the public as a whole will accept it. Hospitals are just afraid to start it."

IT WORKED OUT NICELY

"Here at our hospital we had our first request for admission of a Negro woman this year—a veteran awaiting a V.A. bed," the administrator of a privately owned hospital in Maryland related. "We accepted on a trial basis, apprehensive of how the other patients would receive her. It worked out nicely. We would be willing to try it again."

From a large religious institution in Missouri came this comment: "I am confident that the time will come when segregation in hospitals will be eliminated. Having separate hospitals for each makes this difficult at present. We shall strive to be Christian in our efforts to destroy discrimination. I do not believe a divided, segregated hospital is our immediate answer to the fact that Negroes are now not admitted except for emergencies."

"This is a small hospital for the colored only," said an Alabama administrator. "Three other small hospitals serve the whites only in this city. However, if we really wish to give good health service, Plan A is the only one. Small hospitals are expensive if you give good care. A pooling of resources would help everyone."

"We are here to take care of sick folks," said one in Missouri. "The color of their skin or eyes makes no difference to us, as long as they pay their bills—and we don't really pay too much attention to this." And this from Tennessee: "Segregation should not be mandatory in case of need. The primary purpose of the hospital, to relieve pain and suffering due to illness or injury, should never be clouded nor forgotten."

A number of the administrators expressed personal and professional repugnance to segregation but voted for it because they felt their communities not "ready" to accept anything else. The following comments are typical of this group:

"As an individual I would prefer Plan A. However, as our community is definitely segregated, Plan B is the only possible one at this time."

"Our community is not yet ready for complete integration, but I believe that it is coming. We have had a few complaints when we have had to place Negro and white persons in the same room, but so far we have been able to avoid any serious unpleasantness."

"This is a border state. There is considerable emotional reaction toward Negroes in same wards as whites. Hospital authorities prefer nonsegregation but do not consider it advisable at the present time."

Administrators who favored Plan B, admission with segregation within the hospital, commented as follows:

"There probably would be a laxity on the part of the best trained doctors to administer in a separate hospital for Negroes, therefore I would say that they should be in the same hospital with whites (separated) and receive the same consideration."

"We operate a separate hospital for Negro patients and we are changing to Plan B. . . . It will be more economical for us. . . ."

"In our size community (20,000) we feel that one hospital to service white and colored patients is the only economical and practical approach to patient care."

"My community could not afford Plan C and certainly would not accept Plan A."

"Beds for Negroes are arranged as needed. . . . Negroes are usually given a private room with bath at semi-private rates."

"Since racial prejudices are not yet adjusted in this section of our state . . . it would be best to have the white and the colored patients in separate rooms, in the same hospital. This would preserve the physician's time. Otherwise they would have to stop in two hospitals, which is time consuming."

Comments in favor of Plan C (for separate hospitals): "It is my opinion that segregation is desired by both colored and white races. The Communist party naturally is making an effort to create friction among all groups."

"Segregating the Negro and white patients is done as well as it can be under conditions present (this hospital is constructed differently from the usual) because both races prefer it this way."

"We expect to open another wing for private Negro patients. . . . This hospital will be directed and operated by an all-Negro staff, provided personnel is available—this includes Negro physicians."

"————has a city ordinance that no colored person will be allowed to spend the night in the city limits. . . . As superintendent of this hospital I would refuse hospitalization to a Negro in an emergency, regardless. This problem has never arisen."

The problem of hospital care for Negroes in one Texas community is a purely hypothetical one, for colored persons are not allowed in the town. "This small town of approximately 3000 people does not admit Negroes to any part of any function of the town. Negroes are not even allowed to work as laborers, servants or to come in with road crews from the railroad, oil rigs, seismograph, and so forth. Race prejudice runs very high with occasional hostilities. Within 12 miles of here there are several road crews of Negroes who are not allowed to use this hospital by demand of public opinion."

The Negro doctor has an even rougher time of it than his patients. In many establishments, seemingly, the only way he can gain admission is to get sick. For only 31 per cent of the hospitals stated that Negro doctors were granted staff courtesies. Among the institutions with no racial bar for doctors was one in a deep-South state where, according to the administrator: "Reputable colored physicians are placed on our active medical staff with the same rights and privileges as other physicians."

In Mississippi, one administrator stated that he "would be most happy to admit Negro doctors but because of the existing segregation customs and laws we cannot do so as yet."

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Number and Per Cent of Southern Hospital Administrators Favoring Each of Three Alternatives Relative to Racial Policies in Hospitals in the South by States

	PLAN A Without Segregation		PLAN B With Segregation		PLAN C Separate Hospitals		OTHER AND BLANK		TOTAL
STATE	No.	%	No.	%	No.	%	No.	%	
Alabama	3	8	30	86	2	6	..	..	36
Arkansas	3	15	13	70	2	10	1	5	19
Delaware	1	13	6	74	1	13	..	..	8
D.C.	3	75	1	25	0	..	..	..	4
Florida	6	11	34	64	9	17	4	8	53
Georgia	0	..	27	75	6	17	3	8	36
Kentucky	12	26	23	51	4	10	6	13	45
Louisiana	0	..	26	93	2	7	..	..	28
Maryland	8	33	13	55	2	8	1	4	24
Mississippi	0	..	19	76	2	8	4	16	25
Missouri	14	37	14	37	2	5	8	21	38
New Mexico	16	59	5	19	..	..	6	22	27
North Carolina	4	10	24	58	12	30	1	2	41
Oklahoma	9	21	26	62	2	5	5	12	42
South Carolina	1	5	13	62	4	19	3	14	21
Tennessee	6	15	25	61	5	12	5	12	41
Texas	23	15	98	67	13	9	13	9	147
Virginia	5	12	26	63	4	10	6	15	41
West Virginia	11	32	16	46	4	11	4	11	35

Time and Motion Studies in the OPERATING SUITE

MINOR OPERATING ROOMS

FREDERICK E. MARKUS

Markus & Nocka, Industrial Designers and Engineers, Boston

1

FOR the purpose of this study, it is assumed that minor operating rooms (an accepted terminology which some surgeons do not consider appropriate) are those set aside for eye, ear, nose and throat work.

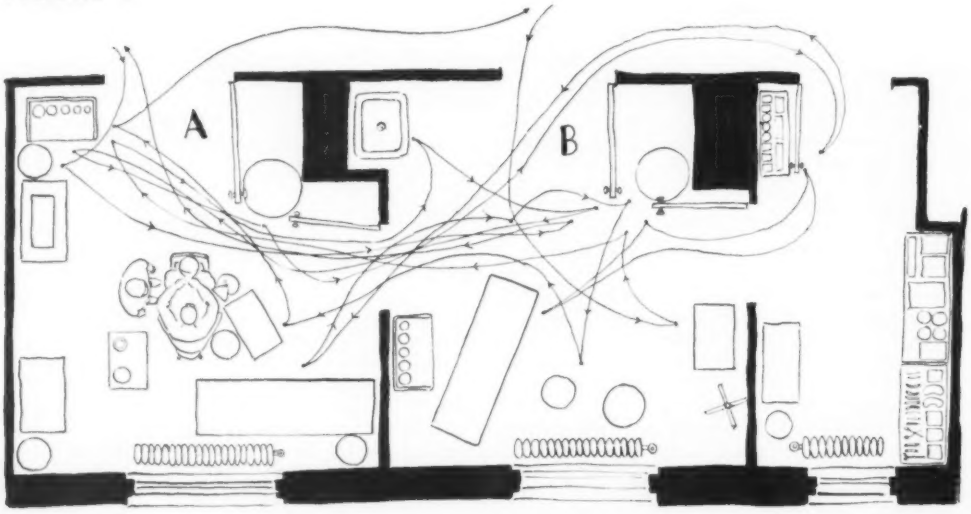
As a preliminary, we have taken note of (1) where equipment and apparatus are stored, (2) how they get into position for use, and (3) the shape of the working ensemble. After these matters have been cleared up, the movement of the staff becomes of interest.

One would assume that storage is always near the point of use. Frequently, however, that is far from being the case for the simple reason that suitable provision for storage was not anticipated at the time of planning. Nor is function used as a guide to location. Note the excessive travel made evident in the tracing of the nurse shuttling back and forth between distant points in Figures 1 and 2.

The entrance doors which are generally 4 feet wide also waste much space in proportion to an otherwise small room. As a rule, they are centered on the room. By its swing, a 4 foot strip of the room is made useless. Whatever enters tends to collide with the operational setup. It would be much better to have these doors off center in line with the natural flow of traffic.

It will also be noted that the shape of the operational setup is roughly triangular. Therefore, the room or enclosing walls need not necessarily be rectangular. While the examples used by way of illustration are rec-

FIGURE 1



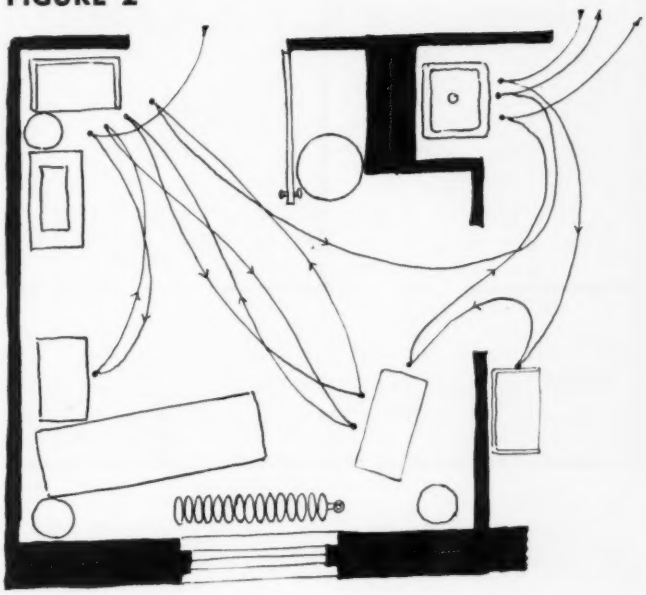
tangular, other shapes have also been used successfully.

Referring again to Figures 1 and 2, it is evident that there is a lack of concentration for those essentials which enter into the nurse's routine. As in most of the cases studied, one nurse took care of two simultaneous operations under rather handicapped circumstances. Thus, on the basis of more nearly ideal conditions, it is reasonable to assume that one nurse might actually serve three operations. Theoretically, one could visualize such an arrangement somewhat on the order of that shown in Figure 4.

From these studies, the general conclusion that minor operating rooms are usually relegated to odd spaces was reached. It would seem that their shape, size and arrangement are largely a matter of chance. Actually, not only should their design be on a precise functional basis but if there are several rooms serving the same purpose, they should be exactly alike.

Numerous flow tracings of nursing travel were made during preparation, procedures and cleanup. Two samples are illustrated herewith. In Figure 1 are two adjacent minor operating rooms with adjoining supply room. One nurse supervises the two rooms simultaneously. In Room A, tonsils are in the process of being removed. Cleanup is in progress in Room B. The nurse's travel was traced from an arbitrary point until more lines would only have confused the illustration. The reason for each trip was also recorded. The excess travel speaks for itself.

FIGURE 2



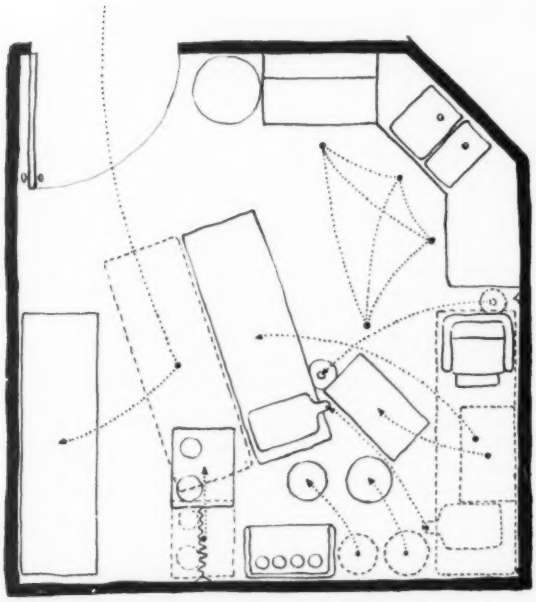


FIGURE 3

2

In Figure 2, one sees a portion of the nursing travel during preparation for another tonsil case. These travels should be contrasted with the proposed solution in Figure 3, which is based on functional considerations.

3

Figure 3 illustrates a single minor operating room complete in itself. Note the directness with which equipment can be positioned. The double triangle is the theoretical pattern of a nurse's travel and would be comparable with that illustrated in Figure 2.

(*Continued on Page* 82)

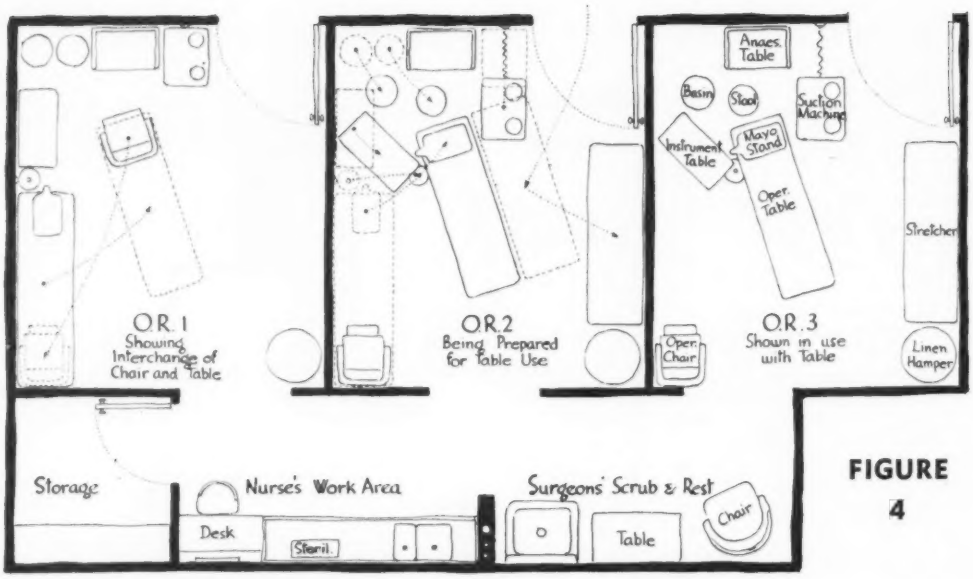


FIGURE 4

Illustrated here is a set of three minor operating rooms with work and scrub space tied in. Again, note the directness with which equipment changes from in and out of use positions. In addition to improved flow of equipment and personnel, these solutions also save space over rooms now considered satisfactory.

A Reading Guide for Administrators

Compiled by

JOSEPH P. PETERS

Division of Medical and Hospital Resources
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PEOPLE who work in hospitals or who deal with hospital and related problems realize the difficulties of keeping informed of significant achievements and developments in the field. Administrators, trainees embarking on careers in hospital or medical administration, department heads and employes preparing for advancement, trustees desirous of obtaining background knowledge, planners and others seeking information on particular aspects of hospital and medical care are constantly seeking reading material to supplement their experiences and broaden their perspectives.

A person approaching the maze of literature in the hospital and allied fields can easily lose himself in the myriad technical details and fail to gain any insight into the broad trends and problems. This is particularly true in the case of those surveying the field for the first time. A reading program should in its early stages be selective, for, to use an apt analogy, too much fertilizer can kill the plant. To avoid these dangers, the accompanying list was originally compiled as a suggested guide for personnel and trainees in the various Public Health Service hospitals and stations. Many able specialists and administrators in the Bureau of Medical Services of the Public Health Service collaborated in its preparation.

This list of books and articles, while far from being complete, or representative of all points of view, is designed as the basis for a long-term reading program for people in the hospital field. It is also hoped that it will prove useful as a reference guide for persons wishing to familiarize themselves with specific aspects of hospital problems and activities and as a refresher reading list for those who may wish to brush up on subjects in which they have had training and experience but in which they are somewhat rusty.

A well designed reading list should afford an opportunity for the reader to develop a sound philosophy of administration and medical care, to gain some understanding of the rôle of hospitals in providing such care, and finally, to develop insights into the specific rôle played by each operating department or activity within the hospital in attaining the basic goals of the hospital. At the same time, it should be comprehensive enough to permit the

(*Continued on Page* 142)

How to Buy INSURANCE for the hospital

2. HOW MUCH COVERAGE—WHAT IS THE COST?

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OF SPECIAL importance to the hospital administrator or business manager is the cost of the insurance necessary to protect the financial integrity of his institution. In these days, when hospitals are caught between rising costs and public criticism of the high cost of hospital care, it is natural for them to wish that the cost of insurance (sometimes considered a "necessary evil") could be minimized. It has been our experience, however, that few hospital managements realize to what extent they can control these costs.

Inasmuch as the burden of analyzing them and of providing the supervision necessary for this control in most cases falls on the administrator or his business office, it is principally to him that this discussion is directed.

THREE BASES FOR COSTS

The cost of maintaining any program of insurance is largely dependent on:

1. Kinds of insurance purchased.
2. How much of each is purchased.
3. What rates are paid.

The kinds of insurance to be purchased must be the decision of each individual administrator or business officer. No set program will be correct for every hospital, because there are so many variables, such as the attitude of the board of directors, the financial resources, the investment, the hazards, and so on for each hospital.

Some hospital boards are quite "insurance conscious" and wish to insure against almost everything that can happen, while others are willing to assume the unimportant losses, such as plate glass breakage, burglary and hold-ups, damage by springler leakage, but want to be indemnified for all losses in excess of $5000, or $10,000, or maybe $25,000.

One question which many persons think it prudent to ask is: What risks do most corporate and institutional managements customarily insure, feeling that they could properly be criticized if they fail to provide coverage. Such a program will usually include:

1. Insurance against destruction of buildings and contents by fire, windstorm, explosion and the supplemental perils.
2. Legal liability for accidents, such as workmen's compensation, general and automobile liability.
3. Explosion of boilers and other pressure containers.
4. Loss through dishonesty of employes.

In addition to these, there are certain risks peculiar to hospitals which may well be insured, such as (1) malpractice liability, with particular relation to negligence of nurses and other employes, dispensing and compounding of drugs and so on; (2) loss of radium needles and similar losses.

Finally, there are optional coverages of many sorts, in particular, insurance against loss of earnings by reason of property damage; loss of money by burglary of safes, robbery of custodian, either in the office, or outside the premises; loss of property held for account of patients.

A hospital is like other business enterprises in that it owns property, buys and consumes supplies, and sells its services (and some of its merchandise) to the public; it employs help; it occasionally undertakes building construction, and it is exposed to property loss and accidents.

The hospital is peculiar in that it invites the public to come into its premises for healing and also invites the public to visit its patients. By its very nature it promises the best of care and complete safety, while dealing with all the vagaries and types of human beings—sick and well, honest and dishonest, rich and poor.

THE BOARD MUST DECIDE

Finally, with the exception of the privately owned institutions, the hospital is dependent for support and development on gifts and bequests from the public, as well as on the fees of its patients; therefore, the interest of the public must be safeguarded by what the board of directors must decide is proper and adequate insurance, or else it may be held guilty of misfeasance, malfeasance, or nonfeasance.

In general, the amount of insurance contracted for against loss of property will be determined by the value of buildings and contents. The amount of earnings insurance will depend upon the annual amount of net profits, if any, and of the expenses which must be paid even if the earnings are suspended. As to the proper amount for investment properties, this will depend upon rentals. Workmen's compensation insurance must cover all employes of whatever nature. Liability and property damage insurance is bought in variable limits. Each must be considered according to its scope.

Buildings and equipment are commonly insured, and losses are paid, on the basis of current new cost *less incurred depreciation*. The hospital

This is the second article in a series on "How to Buy Insurance for Hospitals." The first article appeared in the July issue.

management will have to pay for repairs and replacements on the basis of current *new* cost, and so will have to pay from its own funds whatever is deducted for depreciation, which may be anywhere from 1 per cent to possibly 50 per cent of new cost, depending upon the age, state of repair, and useful life of the items.

Insurance companies usually insist that the amount of insurance shall be at least 80 per cent of the depreciated value, or sometimes 90 per cent, but are willing to make some discount of rate if the insured will agree to keep the amount up to 100 per cent. Under rare conditions they will accept the risk with no stated percentage, or co-insurance requirement, but will then raise the rate so as to make it of slight advantage to insure for less than the normal requirement.

FULL REPLACEMENT COST

It is possible to buy the building and/or the fixtures' insurance on the basis of full replacement cost with no deduction for depreciation. In such a case the total insurance should equal 100 per cent of what it will cost at current prices to duplicate the property new. This has the advantage of eliminating any drain on operating surplus, or requiring some extraordinary fund raising campaign, to cover some deduction from the loss because of depreciation. While this will increase the insurance expense, the amount of increase will seldom exceed the amount of depreciation which will be deducted on some small loss.

The next article in this series will discuss how to determine property values and depreciation, and explain the co-insurance clause and its application to loss adjustments. A later article will discuss at greater length the meaning of "limits" in liability policies and what limits should be insured.

As for the amount of boiler explosion insurance to be purchased, this should be based on the replacement cost of the installation less incurred depreciation, plus the amount of damage which might be caused to adjacent property belonging to the hospital, plus whatever amount of damage the explosion might do to property of neighbors. The more that is purchased the lower the rate per $1000 becomes. The explosive force of a steel boiler under excessive internal pressure may be tremendous, and damage may run high if the boiler, or sterilizer, or pressure cooker is in the center of an expensive building or has other buildings close by.

Dishonesty losses of relatively small amounts occur frequently, but catastrophe losses may be suffered if some trusted employe has been stealing for a long time, or more quickly where two or more employes are covering up for one another, or where some official goes wrong. A blanket bond covering every employe in a limit of $2500, or $5000, is not too costly, and it will usually be cheaper to buy a $25,000 or a $50,000 blanket bond than to attempt to buy varying amounts for various employes.

The premium or cost of each policy will be based on a rate per $100 of insurance, or per $100 of wages, or in some cases on the area and frontage. These rates are established by bureaus, usually under the supervision or with the approval of the state insurance commissioner. Sometimes the determination of the rate for policies will be simple, and sometimes complicated, but always they will be dependent upon the accumulated loss experience for classes of construction, protection, and so on, and by types of occupancy; often, rates will be based on particular conditions and particular losses.

DOES HAVE CONTROL

The insurance buyer usually feels that he has no control over the rates he is charged, but actually he does have, or can have, a great deal to do with the setting of his rates. For example, the administrator gives an order to an agent to write $20,000 of fire and extended perils insurance for a particular building, or for its contents. The agent looks up the rates in a rate book published by the bureau having jurisdiction; here he finds that the building rate is 50 cents and the contents 75 cents per $100 per year, subject to the 80 per cent co-insurance condition.

Where did those rates come from? Well, at some time in the past a bureau inspector examined the property and, in accordance with a rather complex schedule of charges and credits, he arrived at these results. Most agents do not make any further effort to determine the rate than to "look in the book," ignoring the possibility that the rates there given were fixed several years previously, and that many conditions may have changed. Once the rating bureau has published rates, it will not refigure the details until some agent files a request for a rerating.

However, if the agent or the assured asks for the detail of the rate make-up, it will be readily furnished by the bureau, and usually an inspector will explain how defects can be corrected and what reductions will be granted therefor. Often, relatively high penalties are included for "faults of management," such as lack of necessary covered metal trash barrels, broken windows, and unsafe smoking, for the purpose of pressing the insured to make the necessary corrections, but if the agent does not learn of these defects having been remedied and convey the information to the buyer, these charges may be levied for years.

NEVER CHANGED THE RATES

In a recent fact finding survey for a new hospital client, it was found that the rates being charged in the current fire policies were promulgated 15 years previously and had never been changed, whereas the proper number of fire extinguishers had been installed in the meantime. The hospital was therefore, entitled to a 5 per cent reduction of the building and contents fire insurance cost, which was immediately obtained. Four years earlier the hospital rating schedule had been revised, and had a rerating been requested a 25 per cent reduction would have been allowed; but since the policies had been written for a term of five years, the agent had ignored the matter.

In another case it was found that a client had been paying a charge of $1 per $1000 on the building and contents insurance for the last 10 years because when the rates were last promulgated there were insufficient trash cans on the insured's premises. This deficiency had since been corrected.

It is impossible to go into further detail about the rating procedures for various other kinds of insurance, but an audit of the detail of the hospital's rates, and particularly the questioning of charges or credits for loss experience during recent years, may prove highly profitable; also the discovery and correction of wrong classifications may be possible. The point is that rates and rate schedules need to be reviewed by a competent person every year.

The business manager should not jump to the conclusion that the companies and their rating bureaus are cheats. They are always ready to correct rates and to refund premiums whenever they find them to be due. The faults we have indicated are in part those of the agent, and, in part, the management's for not requiring the agent to show that he has done what it has been assumed he will do. Unfortunately, however, once the agent or the broker has obtained an account, he is likely to turn the details of renewals and additional orders over to his clerks. Many of them will wait until the next three-year or five-year policy expires before devoting time to rate check-ups; and not 20 per cent of the agents and brokers could understand the technicalities of the rating schedules if they saw them.

The person responsible for the purchase of insurance for the hospital has a right to see a copy of the schedules showing the calculation of the rates he is paying, and he should insist on having each charge explained to him and a thorough study made to determine if improvements have been made, or could be made, which will reduce these rates. They should be reviewed annually. The agents should be required also to advise the buyer regarding any general class of reductions in rates as they are made, for it may be worth while to accept a short-rate cancellation of existing policies so that they can be rewritten under the new rates. Such reductions are being granted from time to time as loss experience develops.

SUBMIT PLANS TO BUREAU

Before any major alterations or additions to buildings are made, the plans for these changes should be submitted to the rating bureau with the request that it determine what effect the changes will have on the insurance rates, and suggest modifications which would prevent any possible penalties. In several instances an addition has been made to a building which increased the insurance rates because of an excess area charge, when the installation of fire doors on an opening to the new area would have eliminated this charge. It is often better to invest a few more dollars in an improvement at the time of construction than to pay for the lack of this improvement year after year in higher insurance premiums.

It is with respect to workmen's compensation insurance that we have heard it stated oftenest that there is nothing anyone can do about the cost, "for after all the rates are set by the state and must be followed by all companies." This is true, in part, but to the extent that the hospital management can prevent or reduce the injury of employes and control their costs, they can also control the cost of the insurance. Experience indicates that the number of accidents and their severity are in direct relation to the emphasis placed on safety by management.

FIVE THINGS TO WATCH

There are five ways in which the hospital management can control the costs of this type of insurance:

1. By careful selection of employes, physical examinations, and training.
2. By energetic safety programs and employe safety committees.
3. By supervision of medical costs.
4. By verification of experience rating forms.
5. By checking calculation of payroll computation and audit statements.

Oddly enough, hospitals are considered poor workmen's compensation risks, partly because of the occurence of hernias among nurses, student nurses, and attendants. These and other types of accidents can often be prevented by a careful selection of employes to determine their fitness for the duty to which they will be assigned, by physical examinations to discover previous physical infirmities and tendencies toward certain ailments, and by careful training of new employes in their duties. Hernias are not caused so much by lifting as by the improper method of lifting.

Safety should be the concern of both management and employes. Unless management is willing to be 100 per cent behind its safety efforts and will rigidly enforce its safety regulations, any safety program will surely fail. Management cannot effectively carry out a safety program without the interest and cooperation of employes, and employes will tend to resist and resent safety regulations unless they are aware of the reasons for them, and have a part in their formulation.

The best way to obtain this cooperation is through safety committees, made up jointly of representatives of management and employes, which will investigate unsafe conditions and equipment, study the reports of accidents to determine means of preventing further accidents of the same sort, and set up safety rules for the hospital. Safety engineers of insurance companies are available for studies of the causes of accidents and their prevention, and will assist in setting up safety committees and in their training. The hospital should welcome their suggestions and ask for their assistance.

One of the reasons for the poor compensation record of hospitals appears to be the higher than normal medical costs for the treatment of injured employes. This is reported to be caused by a tendency for doctors to make bed patients out of injured hospital employes and prolong their period of treatment beyond that of insurance company clinics or industrial doctors.

Since, in the long run, the hospital will pay for these excess costs in the form of increased insurance premiums, the hospital insurance buyer has a decided interest in investigating such excess costs. He probably cannot tell any of his doctors how to treat employes, but if he suspects that any doctor is unnecessarily increasing the cost of medical benefits, he certainly has valid reasons for making a careful comparison between the costs of medical treatment to his patients and the costs normally encountered by insurance companies for treating similar injuries.

DOCTORS DON'T UNDERSTAND

The insurance companies will be glad to cooperate in such a study, for they too are interested in keeping down the losses. It is probable that the overly liberal doctors simply do not understand how their actions affect the overhead costs of the hospital and, eventually, the cost of hospital care to their own patients. Some general hospitals have even gone so far as to absorb the treatment of injured employes as a part of their operating costs, with the provision that their workmen's compensation insurance policy will be written on an "ex-medical" basis to exclude medical benefits. They will thereby profit by the substantial reduction in insurance premium that results.

The rates charged for compensation insurance for a hospital whose annual insurance premium is $300 or

more are governed by the loss experience of that institution. In other words, the State Workmen's Compensation Rating Bureau starts with Manual rates which are applied to every hospital within the state, and then modifies these Manual rates with either a credit or a charge, depending on whether the experience of a particular hospital is better or worse than the expected experience for all hospitals. This experience is based upon a three-year period, not including the last policy year.

The usual type of insurance buyer has no idea whether his rates are correctly calculated or not, and as a rule his agent will simply tell him that the rates were determined by the bureau and that he has no control over them. Actually, there is nothing sacred about the calculation of these rates. The rating bureau will furnish the hospital or its agent a copy of its "Experience Rating Form" which will show just how the experience modification and the adjusted rates are arrived at.

The careful insurance buyer will obtain a copy of this form each year, obtain an explanation of each item on the form, and will check the correctness of the actual losses paid, the reserves set up by the companies for open cases, the earned premiums shown for each of the years covered by the experience period, and the mathematical calculation of the adjusted rates.

The rating bureaus are not infallible, and mistakes will occasionally be found in their arithmetic, or in stenographic errors, or misplaced decimal points which affect the outcome of the calculations. There have been instances in which large reserves have been set up by a company for injuries and used in the modification of the insurance rates; when, at a later date, the injury was found not to be compensable, the rating bureau was not advised of this decision and the rates continued to reflect a reserve for a claim that was never paid.

All compensation insurance policies require that a deposit premium be paid at the inception of the policies, based upon an estimate of the annual wages paid to employes with the provision that periodically or at expiration there shall be an audit of the actual pay roll for the period covered and an adjustment of the premium based upon this audit. The business office of the hospital will pass an invoice without verifying the calculation of the amounts, and seldom will bother to verify the pay roll upon which the compensation premium is calculated or the figures shown on the final audit statements.

The rules provide that premium will not be charged for wages in excess of $5200 per year per person, or on bonus pay for overtime. Furthermore, it is important that only the value of room and board actually furnished to doctors, interns and student nurses (in accordance with the agreement between the hospital and the company) be included in the calculation of the earned premium.

Rates for various liability and crime policies are also subject to modification according to relatively good or bad loss experience. It is discretionary with the insurance companies whether they shall charge the Manual rates or apply to the national rating bureaus for "experience rating," and often it is up to the agent to request this experience rating. While it is true that in most cases this experience rating is correctly handled, Manual rates are occasionally charged, even though the assured would qualify for experience rating.

This may be to the assured's advantage if his experience has been poor; on the other hand, he is being unduly penalized if his experience has been good. The only way the buyer can check on this is to request an annual record of losses paid and premium earned. If he finds that the ratio of losses to premiums earned is less than 50 per cent, he should receive a substantial reduction from the Manual rates. If his loss ratio is above 70 per cent he should not be surprised at a debit. If it proves that an experience credit should be expected and Manual rates are being charged, the hospital management certainly has valid grounds for asking for a satisfactory explanation of the agent's failure to obtain an experience rating.

COMPANIES OFFER SERVICE

In the fields of liability and crime insurance, many companies offer valuable service through safety engineering and crime audits which are designed to uncover potential sources of injury or loss. Hospitals should take advantage of these services as a means of preventing possible suits and losses and ultimately as a means of keeping their insurance costs to a minimum.

It is evident that only the well informed insurance buyer will be able to realize just how much he can control the costs of his insurance. The business office that simply accepts its insurance policies and pays the premium charged will never know whether it is paying correct premiums or whether its costs are at a minimum. Only a systematic study of each type of insurance will determine whether proper control is being exercised. The person who is responsible for insurance for the hospital must either be willing to devote a great deal of study to his insurance coverages and the methods of determining their costs, or he will do well to turn to the independent insurance consultants for this help. "Control" is active investigation and not passive acceptance.

ADMINISTRATIVE CAPSULES

WE NOW HAVE THE DEGREES of Bachelor of Medicine, Master of Surgery, Doctor of Medicine and, most recently in this country, Doctor of Medical Science (as if the doctor of medicine might be something else). The next degree ought to be Doctor of Social Medicine. More and more people are beginning to think that the solution of the national and international problems of our time lies in the hands of the social physician.

MEDICALLY SPEAKING, age is a cumulative phenomenon—like practical experience.

WHAT CAN WE DO about medical care executives and other social workers who are highly placed and who will not apply a new idea, though it may be very valuable, only because it did not originate with them? What would happen to surgery if surgeons behaved that way?

HOSPITAL CARE IS BENEFICIAL when the patient needs the bed. It is detrimental when the patient does not need the bed.

THE RECONCILIATION between youth and age will be one of the great achievements of social medicine.—E. M. BLUESTONE, M.D.

A simplified system of

Medical Records for Outpatients

HELEN B. McGUIRE
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Division of Hospitals
U.S. Public Health Service

THE traditional attitudes toward medical care of ambulant patients in outpatient departments of hospitals and in various types of clinics have undergone radical changes in the past few years. Because of this change the outpatient clinic of today is being converted into a modern medical care facility rather than a "dispensary" for treating minor illnesses or injuries.

An effective outpatient medical care program requires careful planning and the development of new and better medical administrative technics, so that patients may receive well-rounded medical services quickly and with a minimum amount of inconvenience. Medical and administrative organization in an outpatient facility, therefore, is becoming increasingly complex.

The growing pains are less noticeable in the outpatient department, which functions as part of a well-run hospital. There, the mechanisms and organization already exist in the hospital; they only need to be extended and adapted to include the outpatient activity.

THE PROBLEMS ARE DIFFERENT

The independent outpatient clinic, however, usually must develop administrative methods new to its operations and for which there are as yet few tested and accepted standards.

An important part of any medical care activity is its medical record system. In the evolution of the outpatient clinic, more and more medical specialization has developed and more special diagnostic services have been added, but the medical record has not always kept pace with the changing practice of medicine. It still is not uncommon to find individual specialty clinics maintaining their own card files of case record information—admittedly valuable to the clinic in treating the patient's immediate illness but of no use to the other clinics which also may be treating the patient or which may treat him later. Such a fragmented and dispersed record system makes it difficult to treat the patient as a whole individual.

Our experiences at the independent outpatient clinic operated by the U.S. Public Health Service in Washington, D.C., in attempting to correct the inadequacies in the medical records perhaps may be helpful to similar clinics facing this problem. From observing the results we are convinced that a simple, well organized, and unified record system is an important factor in completing the transition from a traditional dispensary service to modern medical practice in an outpatient clinic.

The clinic provides medical and dental care to patients for whom the Public Health Service is responsible, including coast guard officers and enlisted men and their dependents, merchant seamen, and federal employes who are injured at work. In addition, the clinic does preemployment and other special examinations for federal employes in the area. Approximately 42,000 new patients are seen annually in the clinic. The daily visits average 380, with a total of 96,000 visits per year. The organized special clinics and services are: internal medicine, pediatrics, mental health, nutrition, dermatology, physical examinations, surgery, obstetrics and gynecology, ophthalmology and otolaryngology, dentistry, physical therapy, roentgenology and clinical laboratory. There are also a social service department and a pharmacy.

As a first step in planning an adequate record system to meet the needs of the clinic, we studied those characteristics of the case-load, such as frequency of utilization of clinic services of various kinds, which would have an impact on the record system. Our approach to this problem was to record and classify each visit to the clinic and to its various services during a one-week period. It is recognized that data resulting from such a short period of observation give only a rough index of clinic activity, but, in this case, we felt they were adequate for our purpose.

WHAT THE STUDY SHOWED

Visits were tabulated according to type of admission (direct or referred, first or revisit), place of admission (central admitting office or individual clinic), type of beneficiary, number of clinics visited, and number of visits per patient. The following are the significant facts derived from the statistical study of the clinic activity during the five-day period of observation:

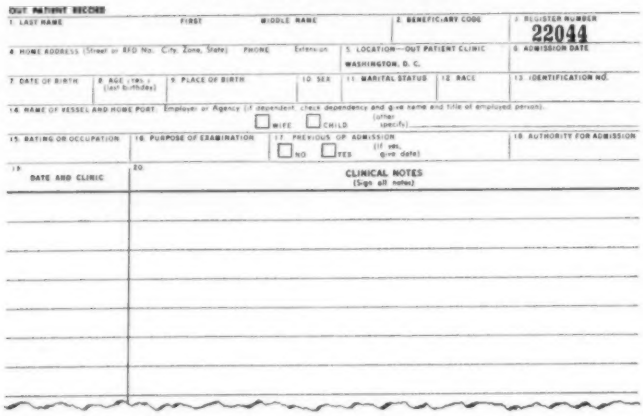
1. A total of 1644 patients made 1940 visits. The average daily number of patients seen was 388.

2. Visits to all clinics totaled 2802 of which 770, or 27.5 per cent, were cleared through the central admitting office. An additional 839 (30 per cent) of the visits were referrals from one clinic to another. In the remaining 1193 visits (42.5 per cent of all visits) the patients went directly to the individual clinics.

3. Of the 1644 patients seen, 68.1 per cent visited only one clinic during the week; 14.8 per cent visited two clinics; 15.2 per cent visited three clinics, and 1.9 per cent visited four or more clinics.

4. A little more than half of the visits were recorded as first visits, although we recognized that there was some inaccuracy in this classification because we could not be sure of finding all earlier records.

FIG. 1—OUTPATIENT RECORD


OUT PATIENT RECORD

1. LAST NAME | FIRST | MIDDLE NAME | 2. BENEFICIARY CODE | 3. REGISTER NUMBER 22044

4. HOME ADDRESS (Street or RFD No., City, Zone, State) | PHONE | Extension | 5. LOCATION—OUT PATIENT CLINIC WASHINGTON, D. C. | 6. ADMISSION DATE

7. DATE OF BIRTH | 8. AGE (This) (Last Birthday) | 9. PLACE OF BIRTH | 10. SEX | 11. MARITAL STATUS | 12. RACE | 13. IDENTIFICATION NO.

14. NAME OF VESSEL AND HOME PORT. Employer or Agency (If dependent, check dependency and give name and title of employed person). (other specify) ☐ WIFE ☐ CHILD

15. RATING OR OCCUPATION | 16. PURPOSE OF EXAMINATION | 17. PREVIOUS OF ADMISSION (If yes, give date) ☐ NO ☐ YES | 18. AUTHORITY FOR ADMISSION

19. DATE AND CLINIC | 20. CLINICAL NOTES (Sign all notes)

The admitting clerk types the necessary information on the face sheet.

This information provided a background against which to examine the total record system. This included admission procedures; initiation of records; types of entries made; methods of filing; utilization and availability of records for revisits, for preparing reports and abstracts and for statistics; methods of transporting records, and the organization and staffing required for these functions.

RECORDS WERE DUPLICATED

In addition to the statistical findings, the study group made a number of significant observations concerning operation of the record system. Admission of patients was carried on in a number of locations, including a central admitting office, the internal medicine clinic, and the dental clinic. Because statistical reports of patient activity were derived solely from the clinical record cards, frequently duplicated in the various clinics, it obviously was impossible to obtain accurate information concerning the actual number of individuals using the total services of the clinic.

The records were often inaccessible and frequently incomplete. Unfiled stacks of loose sheets, such as reports of x-rays and laboratory tests, contributed to the incompleteness of records. There was little incentive for the medical staff to create good records, partly because they were kept on small, 5 by 8 inch cards, and partly because there was no assurance that the record could be found at the time of a later visit. Some records were filed alphabetically in annual or biennial series in the central record room; many were filed separately in the various clinics.

There was a reluctance to permit the records to be filed outside of the immediate office, which apparently resulted from earlier unhappy experiences with undependable central record systems. There was no central index of patients and no certainty that any record card represented all the known information available in the clinic concerning a given patient. The large number of different files in widely separated locations and the high incidence of filing errors within each file tended to discourage a serious effort to find previous records. It often was simpler to start a new record, which also might mean obtaining a new history and repeating various types of tests and examinations.

In collaboration with the headquarters office of the Public Health Service, Division of Hospitals, and the medical officer in charge of the outpatient clinic, we developed a plan for a new medical record system. After the plan was approved, it took about three months to prepare for its installation. New equipment and supplies were purchased, and new record forms were developed and printed. Several meetings were held with medical record personnel to provide orientation in the new system and procedures and to train employes in new technics.

The system, introduced on Jan. 1, 1949, had the following important features:

1. Full-sized 8 by 10½ inch forms were substituted for the 5 by 8 inch record cards.

2. Unit numbering and filing were adopted. A unit number was assigned to each patient on his first visit after January 1, and all of his records were filed in a single folder in such a manner as to present a chronological story. If a patient had records antedating January 1949, these were brought together and filed in a 5 by 8 inch envelope stapled to the back of the chart.

3. A master name index of patients was established. Small index cards, 2¼ by 3 inches were used to save space and to permit easy and rapid reference to the index file. A phonetic system of filing was adopted.

4. Reception and admission of patients was centralized in one area. The receptionist's desk was located close to the admitting desks and convenient to the master name index file.

5. A 5 by 8 inch visit card was introduced to serve both as a statistics card and as the authority for treatment in individual clinics.

STARTED APPOINTMENT SYSTEM

6. An appointment system for all clinics was introduced to permit a more nearly even flow of patients and the procurement of clinical records prior to the patient's arrival. Previously, only a few clinics had operated on an appointment basis.[1]

7. A messenger service was established to carry records from the file room to clinics when patients come without an appointment, and to provide transportation service between clinics.

8. Charge-out cards were employed to assist in maintaining current knowledge of the location of records out of file. These cards are 8 by 10 inches in size, with a distinctive color for each of the principal clinics, thus reducing to a minimum the necessity of writing the name of the clinic to which the record is charged. The register number and date are entered on a charge-out card for each record requested, and the card is placed in the file in lieu of the chart.

Inherent in the success of a unified record system are the clear delineation and assignment of functions and responsibilities, and the development of staff organization to provide over-all

[1] Dental, EENT, Mental Health, Physical Examinations.

management and coordination. It was agreed that the following activities were distinctly medical record functions or so closely related as to indicate the advisability of assignment to the medical record department:

1. Central reception and admission of patients. This function frequently is assigned to the fiscal office because of its relationship to the collection of fees. However, the accuracy of the identifying information, including the assignment of a unit number, that is obtained in the admission interview and recorded on the clinical records initiated at that time, is of vital importance to the successful operation of a unit record system. It has been our experience, both in this clinic and in several of our hospitals, that the admission function can best be carried out under the supervision of the medical record department to satisfy both clinical and administrative requirements.
2. Central reception and secretarial service
3. Maintenance of patient name index
4. Centralized clinical record filing
5. Collection of statistical data of clinic activity
6. Abstracting of clinical records
7. Stenographic service to individual clinics
8. Transportation of records

QUALIFIED LIBRARIAN EMPLOYED

A qualified medical record librarian was employed as head of the medical record department, with responsibility for integrating the medical record system into the total operation of the clinic, for supervising all of the medical record activities, and for selecting, assigning and training personnel in the department.

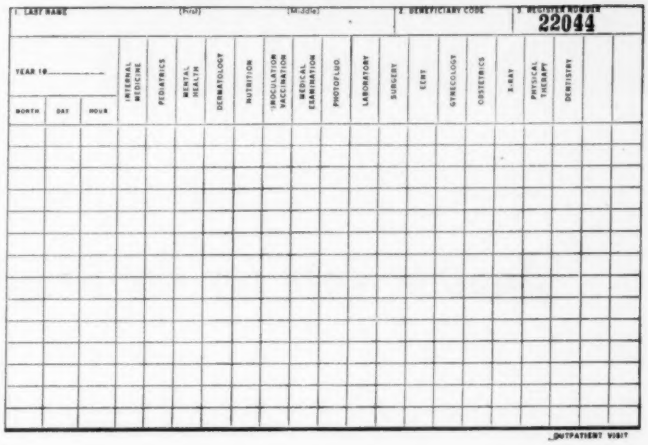
During the first several weeks after the introduction of the new record system, the problems were multitudinous — a common experience when changes are made in procedures that have long been in practice. In an effort to minimize resistance to change and accomplish the transition as smoothly as possible, regular orientation and training meetings were held with the employes concerned, which covered the broad objectives as well as the specific procedures of the new record system. This type of system is dependent upon an unimpeded flow of records from one area to another, requiring speed of operation in every phase. Only real teamwork can prevent bottlenecks and thus contribute toward meeting the objective of prompt, high quality medical care for every patient.

As problems arose, they were discussed in the group meetings, and all of the employes were given an opportunity to help in their solution. These discussions brought about better understanding of mutual problems and developed a realization of the importance of each individual's rôle in the successful operation of the system. We felt that group participation contributed significantly to the solution of problems encountered during the transition period.

In order to obtain a clear picture of the actual operation of this record system, it may be helpful to trace the flow of records and describe the procedures carried out in relation to them.

When a patient first visits the clinic, the central receptionist, whose desk is located close to the entrance, checks the patient-name file to be sure he has not been registered previously, then directs him to an adjacent admitting desk. As he gives the necessary information to the admitting clerk she types the information directly onto a manifold admitting form. This set of forms provides, at one typing, the face sheet of the chart (Fig. 1), a duplicate of the upper half of the face sheet from which the name index card will be made, and the visit card (Fig. 2). (The unit register number is preprinted on all three forms to prevent identification errors resulting from issuance of duplicate or incorrectly typed numbers.)

FIG. 2—OUTPATIENT VISIT CARD



Red dot on the visit card indicates clinic to which patient is referred.

The face sheet is detached from the manifold and is fastened to a chart backer with built-in prong fasteners. Based on the patient's statement concerning his reason for coming to the clinic, the clerk determines the specialty clinic to which he should first be referred. She stamps a red dot[2] in the appropriate clinic column of the visit card and enters the date; gives the visit card and chart[3] to the patient; instructs him to give these records to the receptionist in the specialty clinic, and tells him how to reach the clinic.

HOW REFERRAL SYSTEM WORKS

Upon his arrival at the chosen clinic the receptionist takes the card and chart and passes on the chart to the doctor. After the patient has been treated, the receptionist circles the red dot on the visit card to indicate that the patient has been seen and that a clinic visit may be counted. If the physician should refer the patient to another clinic, the referral is carried out through his clinic receptionist, who stamps a red dot on the card on the same date line for the clinic to

(*Continued on Page* 148)

[2] This is most conveniently done by using the eraser end of a pencil as a rubber stamp.

[3] The chart at this point contains nothing but identifying entries. This is the only time a patient is permitted access to his record.

Small Hospital Forum

Another Vote for the Hospital Laundry

ELLA K. LONGLEY, R.N.
Superintendent, Paulina Stearns Hospital
Ludington, Mich.

I CAN'T think of a single good reason why a small hospital should not have its own laundry. In fact, I dislike the idea of hospitals having *any* of their services run on a concession basis.

A member of the medical staff thoughtfully brings in a basal metabolism machine, makes sure that the right patients are served by it at the right time, and collects the revenue from it forever after; the entire medical staff may chip in and buy other equipment on the same basis, and the local druggist (who, of course, makes a publicized donation to the hospital each year), sells the hospital most of its needed drugs—at prices higher than the hospital would have to pay by direct purchase from the manufacturers.

HOSPITAL SHOULD HAVE CONTROL

As the administrator of a small hospital, I am against all of these practices. I firmly believe that—especially with reference to equipment—the hospital should own and control every single unit, with authority to direct when, where and how long it should be used.

During the last war, I visited a 50 bed hospital which had been designed by one of the best architects in the business. It was beautifully planned, but the directors had omitted a laundry—leaving the services of that department to be performed by a local concern at a cost calculated to be cheaper than could have been approximated by the hospital operation.

Shortly after the hospital opened, the owner of the laundry died. The new management promptly canceled the hospital contract, giving notice that it would be recast at a price almost out of sight. On the day of my visit, some of the laundry was being done—in the emergency room in a domestic machine borrowed from the neighbors. Following this make-shift operation the laundry was hung on the hospital lawn to dry.

Then, belatedly, the hospital powers-that-be took notice and started to work to get priorities for new laundry construction and equipment. I have since learned that the priorities were received—after several months' delay; that a laundry has been built as an integral part of the hospital; that an adequate supply of clean linens is delivered at the same time each day; that the sheets have just enough bleach in them—and no more; that the hospital is pleased with the reduced laundry costs, and last, that the female patients in the hospital are limiting themselves to complaints about noise in the corridors and the infrequent visits of their doctors — coupled, sometimes, with thoughts that perhaps their husbands may be out with "blondes."

Early in my career as hospital administrator I learned a great deal about laundry work — mainly because we were without a laundry manager for almost the entire first year. We had a succession of people who tried the job. Some didn't like the hospital; some didn't like the hours, and some just plain didn't like to wash. Then Mrs. Andersen came along. She had lived for a long time in our neighborhood, and had been a school teacher before her marriage. Now, with her family almost raised, she had what I thought was an eminently proper itch to do something. With her as laundry manager, my problems were solved.

We purchased our equipment and supplies from reliable concerns whose representatives gave Mrs. Andersen their expert advice in setting up technics, procedures and formulas. This meant, in simple language, that she learned when, how and how long to wash all washable cloth as it became soiled.

SHE DOES A GOOD JOB

Being given a rather free hand, she has taken a terrific interest in doing a good job, and has, on occasion, attended short institutes dealing with what is actually a profession. Mrs. Andersen attended one of these institutes last fall, and later gave a fine report of her attendance at a meeting of the women's auxiliary. Every woman in the group seemed to have a laundry problem, ranging from tattletale gray shirts, to makes and types of washing machines, and Mrs. Andersen's answers were all satisfactory and confident.

Paulina Stearns Hospital, Ludington, Mich., is located in the industrial area of the town, where many of the women have seasonal work at the canning factories. Some time ago, 15 of these women organized a volunteer group and received some in-service training in the laundry and dietary departments. This group, known as the Fourth Ward Volunteers, agreed to give two hours per week to the hospital, and the hospital agreed to pay them at prevailing

From a paper presented at the Tri-State Hospital Assembly, Chicago, May 1952.

rates when they were called for extra duty. We thought we had found a new approach to volunteer service, but the group folded in less than a year. However, the reason the group disbanded was because seven of its members accepted full-time employment at the hospital in various departments. Four of them are doing part-time work, and the others gave up the work for personal reasons. It was one of the best recruiting ideas we ever had.

Returning to my immediate subject, I definitely feel that there are many advantages in employing women in the laundries of small hospitals and I say this with all due respect to the male gender. Two years ago when purchasing a new washer we chose the open end upright model because we felt it was more adaptable for women workers.

Don't forget the ladies, particularly the ones who live in the hospital's neighborhood. Families have been raised and households have been run while "Mamma" worked at the hospital laundry. Here the hours are flexible enough for her to work while her children are in school; she has no transportation costs; she has year-round employment, and, above all, she has been thoroughly sold on the idea over the years that she really *rates* if she is working at the hospital.

EVERYTHING HAPPENS TO THEM

Although draperies are primarily the problem of the housekeeping department, they still have to be laundered. Early in the game, we tried various kinds, lengths and materials for draperies. We even went so far off base one time as to try nylon ruffled ones. But, regardless of all our efforts, we found that patients pinned draperies together to keep out the light; hung them up over lamps and other such objects to let in more light, and pinned "get-well" cards on them. Children, who came to visit, enjoyed using the draperies for swings. In short, they were used for almost every purpose except the purpose intended.

We finally solved the problem by hanging only valances 20 inches deep, but—following the old decorating rule that "if you use something cheap, use plenty of it"—we made the valances extremely full—4 yards in fact. This treatment makes attractive windows, especially in the wards which also have cubicle curtains. The valances are easy to launder and they also are easy on the budget, because our local drapery store keeps us supplied with remnants of their best materials—by periodic donation.

No article on the subject of hospital laundries can be complete without some mention of linen control. I wish I could offer some advice on the problem, or rather its solution, but I can't. I can only comfort myself by the thought that others have failed to solve similar problems.

Often, when I get tired or discouraged, I get a big lift by making rounds and visiting our patients, because I always find some of them who tell me that we are doing a good job. Every now and then, someone even tells me that he thinks I'm doing all right as an administrator. I try to remember to tell our Mrs. Andersen, for these are words easy to say and, to those of us who know that they are well meant, are forever treasured.

It is the sick to whose recovery we are all dedicated. To them, the clean, well-laundered sheets are just as important as their treatments and medications. They depend upon the laundry, as does every department in the hospital—the x-ray, the operating room, the dietary service, and the housekeeping department.

NAME PINS introduce staff to patient

LYDIA HEWES
Director of Public Relations, Hartford Hospital, Hartford, Conn.

ANYTHING that adds to patient comfort or peace of mind is worthy of consideration by a hospital. It has been the common complaint of patients that is difficult and often embarrassing not to be able to remember the names of all those assisting with their care. This has finally lead to the general use of name pins at Hartford Hospital, Hartford, Conn.

The first group to wear the identification pins was the dietary department. This was four years ago when the pins were furnished to all dietitians and dietitian aides. Next it was decided to furnish all student nurses with pins along with their uniforms. This has proved helpful in teaching as well as in bedside nursing. About 250 students wear these bar pins.

The idea spread as the patients expressed their approval and now more than 200 graduate nurses have bought their own pins, ordering them through a member of the nursing service department. Other personnel, such as trained attendants and student attendants, also wear them, and the custom is spreading to the personnel in the doctors' offices of the adjacent medical building.

Good public relations is involved in this courteous way of making it easy for the other fellow's memory.

A student and a graduate on the staff of Hartford Hospital display the plastic bar pins that identify them to patients.

About People

Administrators

Dr. Roger W. DeBusk, director of Lancaster General Hospital, Lancaster, Pa., for the last three years, has been appointed director of Samuel Merritt Hospital, Oakland, Calif. Dr. DeBusk will succeed **Ellard L. Slack,** who has retired. A graduate of the University of

Dr. Donald C. Smelzer

Dr. Roger W. DeBusk

Oregon medical school, Dr. DeBusk received his early administrative training as chief resident at the State of Wisconsin General Hospital, Madison, under **Dr. Robin C. Buerki.** He then served for several years as assistant administrator at St. Luke's Hospital, New York City, with the late **Dr. Claude W. Munger.** In 1941 he became administrator of the Evanston Hospital at Evanston, Ill., where he remained for seven years before moving to Lancaster. He is a member of the council on professional practice of the American Hospital Association and is a past president of the Chicago Hospital Council.

Dr. Donald C. Smelzer of Philadelphia, director of the joint hospital development program sponsored by the Philadelphia Hospital Council, has been appointed to succeed Dr. DeBusk as head of Lancaster General Hospital. A past president of the American Hospital Association and chairman of the association's council on international relations, Dr. Smelzer was managing director of Germantown Dispensary and Hospital of Philadelphia for several years before he took over direction of the joint development program. Earlier, he was for 10 years director of the Graduate Hospital of the University of Pennsylvania.

Charles H. Sperley has been named administrator of the Central Oregon District Hospital, Redmond, Ore., which was scheduled to open July 4.

Frank E. Wing retired July 1 as executive director of the New England Medical Center, Boston. Mr. Wing was appointed director of the Boston Dispensary 32 years ago, and in 1929, when the dispensary became a part of the medical center, he was appointed director of the latter also. He was subsequently director of the Boston Floating Hospital and the Joseph H. Pratt Diagnostic Hospital (now a part of the New England Center Hospital), all units of the medical center, which also includes Tufts College medical and dental schools. A fellow of the American College of Hospital Administrators and a life member of the American Hospital Association, he also is a past president and recently elected honorary and life member of the Massachusetts Hospital Association.

Frank E. Wing

James A. Canedy has been appointed assistant administrator of Bishop Clarkson Memorial Hospital, Omaha, Neb. Mr. Canedy recently received his master's degree in hospital administration from Washington University. He served his administrative residency at Clarkson.

James A. Canedy

Edna M. Hayward has resigned as administrator of Wesson Maternity Hospital, Springfield, Mass., a post she has held for the last 26 years. She has accepted the superintendency of Benjamin Stickney Cable Memorial Hospital, Ipswich, Mass., effective September 1. From 1921 to 1922 she was surgical supervisor of New England Baptist Hospital, Boston, and from 1922 to 1926 she was superintendent of nurses at Boston Lying-In Hospital, Boston.

Peter Alexander has been named administrator of Gibson Community Hospital, Gibson City, Ill., which will soon be in operation.

Roy Hudenburg, secretary of the American Hospital Association's council on hospital planning and plant operation, has resigned to accept an appointment as assistant administrator in charge of physical plant of Memorial Hospital Association of Kentucky, the hospital division of the United Mine Workers Welfare and Retirement Fund. The association is planning to build 10 hospitals in the mining districts of Kentucky, West Virginia and Virginia. Mr. Hudenburg has been a member of the American Hospital Association staff for nine years; previously, he was in the real estate management business in Chicago. As director of the U.M.W. hospital building program, he will make his headquarters in Washington, D.C. He expects to move to his new position October 1.

Roy Hudenburg

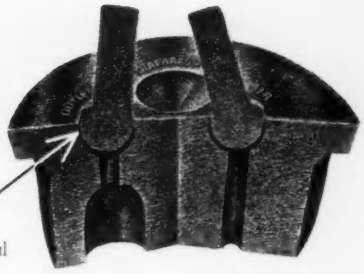
James J. Mayer is the newly appointed administrator of Somerset Community Hospital, Somerset, Pa., succeeding **Mrs. E. O. Haupt, R.N.,** who has served as administrator of the hospital for the last two years. Mr. Mayer, a 1952 graduate of the University of Pittsburgh's course in hospital administration, formerly was administrative assistant at the Lee Hospital, Johnstown, Pa.

James J. Mayer

Warner S. Byars has assumed his new post as administrator of Graham Hospital, Keokuk, Iowa. He formerly served in the office of the administrator at Harper Hospital, Detroit. Mr. Byars received his master's degree in hospital administration in June from the School of Public Health, Columbia University.

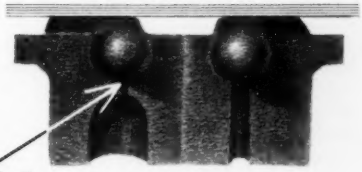
Martin E. Meier has been named assistant superintendent at Lockport City Hospital, Lockport, N.Y. Mr. Meier was business manager of the Lutheran Sanatorium at Wheat Ridge, Colo.

(*Continued on Page* 178)



Primary seal—diaphragm integral part of stopper.

Safer because it's SOLID*



Secondary seal—ball valve under pressure and vacuum.

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Here's simplified technic with closed-stopper safety and open-stopper convenience. Cutter is the only intravenous solution line protected throughout by solid-stopper safety. Good News! This safety exclusive costs no more. Cutter Laboratories, Berkeley, California

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Simplify For Safety With Cutter

 Conducted by Raymond P. Sloan

Economic Aspects of Health Care

from the point of view of the public

HARRY BECKER
Associate Director
Commission on Financing
of Hospital Care
Chicago

IN 1952 we can expect that more Americans will use their community hospital facilities than in any previous year in history and they will receive more and better hospital care than ever before. But at the same time the cost of this care will rise to an all-time high.

These two factors—increased use of hospital facilities and higher costs of providing services—are going to mean that our hospitals this year will present a bill to the American people that is higher than the nation has ever before had to pay. It does not follow, however, that the American people want to reduce this bill by demanding fewer services or a lower quality of care. But from these facts stem the economic problems confronting the public and the hospitals; from these facts stem the concern of the public with the problem of how to allocate money to meet this bill.

INCREASE IS NOT SURPRISING

Higher total expenditures for hospital services should not be cause for surprise. Hospital costs have been rising at an average rate of about 1 per cent a month for the last 10 years. This rise in cost accompanied by a constant upward trend in utilization of hospital services reflects the continued development of higher standards of care. It reflects, too, the underfinancing of hospitals at the beginning of this period and the steady increase during this period in the allocation of funds for hospitals which the prepayment plans and higher consumer incomes have made possible. The general rise in the cost of living has, of course, been a significant contributing factor.

These higher total expenditures for hospital services should not be cause for alarm either. The national policy of an expanding economy and our traditional American drive for continuously higher standards of living call for increasing expenditures by the consuming public for all goods and services that contribute to individual and family well-being. The result of this desire for higher standards of living is an increase in the total national expenditure for goods, such as housing, food, clothing, automobiles and household labor-saving devices, accompanied by rising incomes and productivity. Similarly, over an extended period of time, consumer spending for services, such as hospital and medical care, has been increasing—increasing at an even faster rate than spending for goods. And this, too, is quite generally regarded as means to higher standards of living.

The problem which higher standards and increased quantity of care, increased utilization and new services has created for the public and the hospital is not basically a problem of higher costs. If it were fundamentally a problem of costs being too high we would reduce services and thus lower the nation's health bill. But the consuming public wants the services now received and has the income to pay the bill. The public and the health professions are constantly pointing to the need for more services, not fewer services. There is general recognition of the need for more preventive and diagnostic services of treatment earlier in the course of disease and of comprehensive rehabilitation services. These consumer wants coupled with continuing increases in consumer incomes point to higher national expenditures, and this inevitably means a greater allocation of consumer income to health.

HOW TO FACILITATE FINANCING

The problem, rather than being one or reducing costs, is one of how to facilitate the financing of the increased national expenditures necessary to provide the health services desired by the public. This problem of how to finance more easily and adequately the national bill for health arises because the method for financing expansion and progress has not been as adequately or as extensively developed for health services as it has been for such items as housing, electrical appliances and automobiles.

The effect of a relatively undeveloped method for consumer allocation of income to health care is that increasing hospital and medical costs constitute a threat to progress in improving quantity and quality of services—it even threatens the maintenance of existing standards of care. There can be no solution to the basic problem of financing health services

Condensed from a paper presented at the Association of Western Hospitals convention, San Francisco, May 1952.

without looking beyond the immediate problem of rising expenditures to find the most satisfactory methods for financing more and better health care.

Strengthening mechanisms for consumer financing of hospital care is the first of two central aspects of the problem of hospital costs as they pertain to the public, the hospital and the health professions. The second concerns increased productivity and efficiency in use of hospital facilities and personnel.

When the hospitals and public face their common economic problem of how the total cost of hospital care is to be paid they will have to take into account a number of considerations. The first of these is that the cost of hospital care per patient day for the country as a whole will probably continue to rise at about the same rate in the next few years as it has in the past few years. If this is substantially true—and there are many reasons why it is a reasonable assumption—the daily cost of hospital operation, on an average throughout the nation, may be as much as 20 per cent or more higher in 1954 and 1955 than it is today. And the monthly charge for prepaid hospital care may be expected to rise even more.

COSTS MAY CONTINUE UPWARD

Even though the cost of living should level off, or drop somewhat, the cost of hospital care may still continue upward because the factors which influence the costs of hospital operation are only partly related to the cost of living. Some evidence for this is found in the fact that hospital costs for the last 10 years have risen at a faster rate than has the cost of living generally—an understandable occurrence.

Another consideration on which future planning of adequate methods for financing health services must be based is that more people will tend to use hospital services, and with greater frequency, in the next few years than in the past. Our population is increasing at the rate of about 1½ per cent a year and our supply of hospital beds in voluntary nonprofit hospitals at about twice this rate. With many urban hospitals having waiting lists and with physicians in many cities without satisfactory hospital privileges, this increase in the supply of beds will mean distribution of more hospital care to the public.

The concept of the place of hospital care in our standard of living has been changing markedly for the past half century and will continue to change. The rôle of the hospital is tending to expand in the public consciousness. It is now common practice to turn to the hospital as the place for the care of acute and critical illnesses, for many chronic illnesses, and for extensive diagnostic procedures. Further development of outpatient services for private patients and for diagnostic and rehabilitation services, as well as for home care programs for selected groups of patients, can probably be expected. These services, as they are extended and developed, will increase the total national expenditure for use of hospital facilities and this in turn means that we must develop improved methods for allocation of consumer income to finance these activities.

Experience has shown that in the voluntary prepayment plan concept a method of financing exists which will permit this expansion within our over-all ability to pay. However, whether or not the public and the hospitals can look to the prepayment plans as the basic method of financing hospital care depends upon attaining a higher degree of hospital, physician and public cooperation in making prepayment work than exists today in many communities. In fact, without such cooperation the present effectiveness of prepayment in meeting hospital costs is jeopardized.

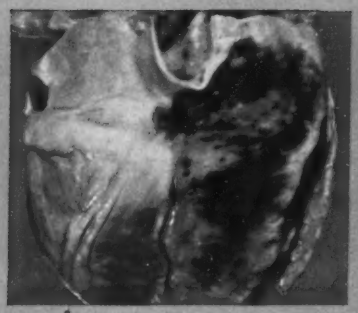
For the last 10 years prepayment as a method for increased allocation of consumer income to finance hospital care has been in the process of becoming a matter of social and public policy. During this time it has also become, together with payments from tax funds for special population groups, the primary source of hospital income. In 1939 less than 5 per cent of the population had any form of prepaid care. Today, well over 50 per cent of the population has some type of prepaid hospital care and a relatively high per cent of the prepaid patient group has reasonably comprehensive protection. Dollar payments to hospitals from prepayment plans in 1940 were negligible in importance as a source of income. Today, however, many, if not most, hospitals would be unable to meet their monthly operating expenses if the prepayment plans were to lose public support.

The prepayment plan is a relatively new economic tool for both the public and the hospital. It is hardly 15 years old—too short a time to introduce a new idea, to obtain its widespread adoption, and to develop adequate understanding of its use by the public, hospitals and the health profession. It is also too short a time to gain the experience necessary for maximum efficiency and most economical use. Nevertheless, there has been sufficient time to make it clearly evident that the American people and the hospitals want to use prepayment as the device for consumer financing of hospital care. The problem of financing hospital care is in large part one of strengthening the voluntary prepayment plans as an economic instrument to meet the needs of the public and of the hospital.

WILL STUDY PROBLEMS

The recently formed Commission on Financing of Hospital Care came to this conclusion when problems associated with prepayment were adopted as one of the four major areas for study. Regional and special conference groups held throughout the country by the commission earlier this year reached the same conclusion, when prepayment was listed by all groups as a major item of concern. With the emphasis that is being placed on prepayment by the commission's half-million dollar, two-year study program, a new public and professional understanding of prepayment can reasonably be expected to result.

Although experience with prepayment is limited and of comparatively short duration, there is little disagreement with the conclusion that it has already been demonstrated to be the most practicable device to use in the long-range planning for allocation of consumer income to hospital care. Prepayment, however, has introduced many problems for which solutions must be found. No matter what short-term answer to these problems may be introduced, the effect will not be fatal because the prepayment approach is sound—the worst that can be said is that the wrong answer to present-day prepayment problems will mean a longer period of experimentation and a delay in achieving the potentialities of prepayment for the public and the hospital. However, because experimentation is costly and in the interim the problem of financing will become more acute, every effort should be made to avoid wrong answers to current problems. (*Turn to Page* 98.)



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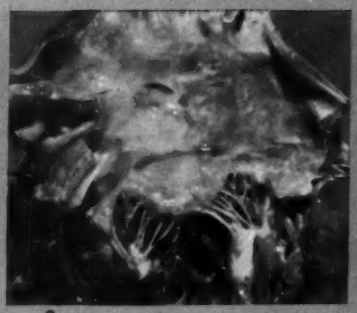

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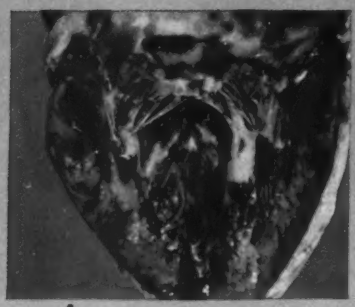

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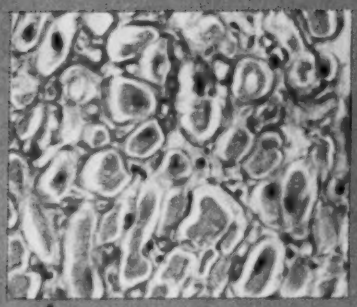

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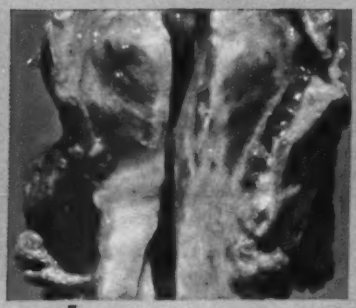

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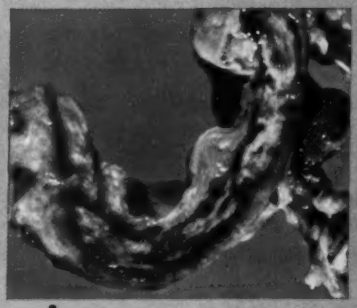

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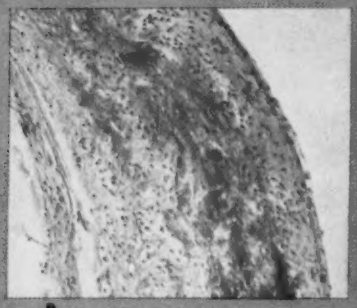

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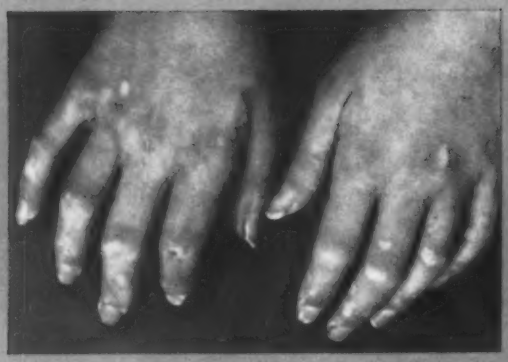
Series from a single case of amyloidosis involving the heart (1-4), larynx (7), and urinary bladder (8). Color photography demonstrates not only the results of staining microscopic sections (6 and 9) but also the effect of the application of iodine to the gross tissues. The resulting dark mahogany-brown color is of diagnostic importance. The method of application of the iodine with a cotton swab is shown (3); also the comparison of a treated and untreated slice (5).

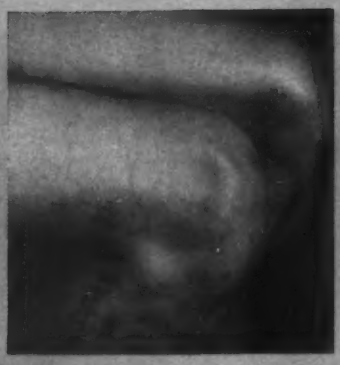
How easy to follow the case . . . *in color*

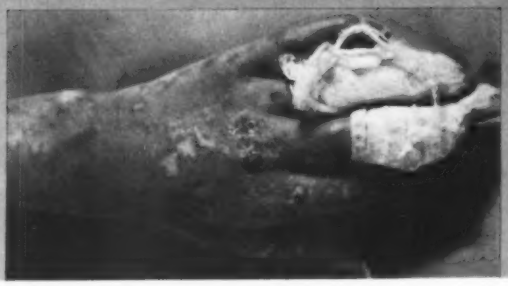
For cases where the color of tissues is important in diagnosis and exposition, color photography is of outstanding value as a recording medium. As in the series above, the significance of color is clearly seen in gross specimens and photomicrographs—there to view and review.

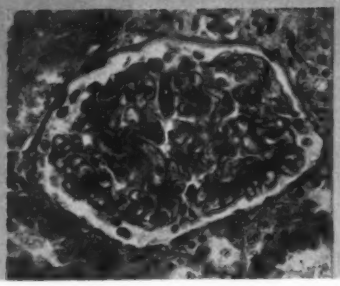
SERVING MEDICAL PROGRESS THROUGH PHOTOGRAPHY AND RADIOGRAPHY

Kodak
TRADE-MARK









A selection of views from a case of lupus erythematosis scleroderma. The change in clinical course is readily noted by comparing the hand pictures.

Record it *in color... to show it as you saw it*

■ No question—when it's in full color. The image is there before you—just as the eye saw the condition itself. What an opportunity color photography like this gives physicians, surgeons, teachers, and students for study, review, research, instruction.

And there's a Kodak color film for every requirement: Kodachrome Film for miniature and motion-picture cameras . . . Kodak Ektachrome Film and Kodak Ektacolor Film, Type B, for sheet-film cameras.

See your photographic dealer . . . or write for further information.

For miniature cameras
Kodachrome Film—35mm. or Bantam—permits Kodachrome Duplicates, Prints, Enlargements.

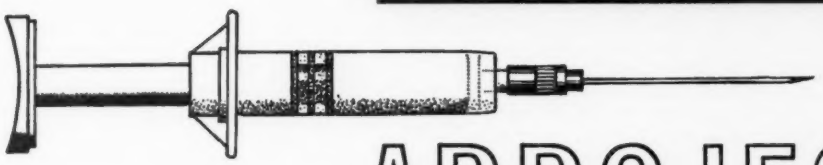
For motion-picture cameras
Kodachrome Film—16mm. rolls or magazines—permits duplicate prints in black-and-white or color.

For sheet-film cameras
Kodak Ektachrome Film permits Kodachrome Duplicates, Prints, Enlargements. Kodak Ektacolor Film, Type B, for master color negatives, permits transparencies on Kodak Ektacolor Print Film.

EASTMAN KODAK COMPANY, *MEDICAL DIVISION*, ROCHESTER 4, N. Y.

Kodak
TRADE-MARK

NEW Disposable Syringe



ABBOJECT

TRADE MARK

containing Abbocillin®-DC, the 48-hour repository penicillin

Repository penicillin therapy is both quicker and simpler with ABBOJECT, Abbott's new disposable syringe containing ABBOCILLIN®-DC—600,000 units of penicillin G procaine in aqueous suspension.

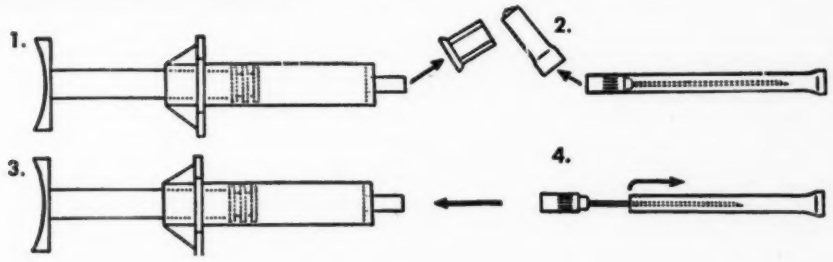
With the ABBOJECT syringe, injection can be made in only a few seconds. No cartridges to load—simply attach needle and you are ready to inject. (See accompanying sketches.) And there is no glass breakage problem, because ABBOJECT is made of plastic.

The double concentration and true repository nature of ABBOCILLIN-DC afford sustained penicillin blood levels for more than 48 hours with a single dose—which means single injections at 48-hour intervals are adequate for treatment of mild to moderately severe infections.

Higher blood levels, when needed for severe infections, can be obtained with a 24-hour or more frequent injection schedule. At such intervals, a cumulative effect results which is especially marked after the fourth injection. ABBOCILLIN-DC is now available in the new disposable ABBOJECT syringe, which is supplied either with or without a sterile 20-gauge needle. Abbott

INSTANTLY READY FOR USE
. . . after these simple steps:

1 *Remove plastic cap from syringe tip.*
2 *Remove blue cover from needle.*
3 *Attach needle to syringe.*
4 *Remove plastic tubing from needle.*



Accepting prepayment as the basic method for paying the nation's hospital bill is imperative if it is to be an effective tool for allocation of the national product to hospital care. Until the head of every family in America feels as unprotected without prepaid hospital care as the home owner feels without fire insurance, or as the mother of small children feels when she is without a telephone in the house, or as the wage earner's family feels without electric lights and electrical appliances, we will not be able to say that prepayment has been adopted as common practice. Nor will the problem of financing hospital care be met.

No other practical mechanism exists which can be employed as an alternative to prepayment for the gainfully employed. From the patient's standpoint prepayment has certainly proved to be more satisfactory than payment of the hospital bill from savings and current income at the time of illness.

IT IS A NEW CONCEPT

Prepayment has, however, introduced for the public and the hospital a new concept of the cost of hospital care. Previously, when the patient met his hospital bill at the time he was ill the amount charged him by the hospital was his basis for measurement of whether hospital costs seemed to him to be too high. Also, before the introduction of prepayment as a source of reimbursement for half or more than half of all patients, philanthropic sources covered hospital deficits, and charges to patients could, therefore, vary with patient ability to pay to a greater extent than is possible today. Prior to the development of prepayment, hospital administrators and their boards tended to translate hospital operating costs into charges on the basis of private patients paying more than cost and ward and part-pay patients paying less than cost.

Prepayment has introduced methods of paying hospitals which more nearly reflect the actual cost of providing services. Today, many patients who were part-pay or free patients yesterday or, conversely, who chose private accommodations, are prepaid patients today. Another recent change in the pattern of hospital income, though not directly related to the introduction of prepayment, is that payments from tax supported agencies have not increased in proportion to the actual cost of providing services, and income from charity has been shrinking as a source of funds for financing care for the free patient.

This situation is well known to the hospital administrator and his board, although not so well known to the public. Less well understood, even by the administrator, is the fact that to persons with prepaid care the daily cost or the cost per admission of providing hospital service is not a significant basis for measuring hospital costs to the public.

Only a few years ago hospital costs were, in the public mind, largely a matter of daily room charges and charges for "extras." There is still a tendency to think in these terms; however, the true measurement of the consumer's bill for hospital care is more and more the monthly cost of prepayments. This means that the cost of hospital care has already been translated, for about half the total population, into a "group cost." Another way of expressing this is that prepayment rates charged the individual or the family are the true measurement of the cost to the public for hospital care —as insurance rates go up, the cost of hospital care to the consumer goes up. Since the per diem cost at an individual hospital is only one of many significant factors which determine the cost of care to the prepaid patient, this concept of "group cost," or monthly prepayment cost, means a new orientation for the hospital administrator and his board in the control and interpretation of costs to the public—a new concept with far reaching implications to the changing rôle of the hospital administrator in public relations.

The shift of public concern from the actual cost of providing hospital care at a given hospital to concern with the monthly cost of prepayment has developed in the past several years. In another five to 10 years the public can be expected to view hospital costs almost entirely in terms of monthly cost of prepayment. Today, for example, the worker with prepaid hospital care, the cost of which is often shared by his employer, is not primarily concerned with the fact that at a given hospital in his community the average cost of care has risen in 10 years from $10 per day to $25 per day, nor is his employer particularly concerned with this fact. Rather, they are concerned with the increase in monthly cost of prepayment which is influenced by many factors in addition to the per diem cost of hospital care.

Looking ahead 10 years, more or less, hospital income will come almost entirely from prepayment organizations and agencies buying care for special groups, such as public assistance recipients. In view of the progress made by the prepayment plans since 1939 this is a conservative assumption. The length of time required to bring 90 to 95 per cent of the population into prepayment depends almost entirely on the extent that prepayment plans, working in close cooperation with hospitals, physicians and the public, are able to meet the particular problems of each interested group. Whether or not the prepayment plans achieve their goal in five years or 15 years is less important than that: (1) prepayment is the most effective mechanism for allocation of consumer income to finance hospital care, and (2) that it will work successfully for 90 to 95 per cent of the population.

RATES WILL HAVE TO RISE

The obstacle today to more extensive development of prepayment of hospital care is *cost*. But the term *cost* does not mean that prepayment costs too much: in fact, to finance adequately the scope of services desired by the public, prepayment rates will have to be increased over a period of time, not decreased or even maintained at present levels. The problem that *cost* presents is two-pronged: the public must be assured, first, that the cost represents real value and, second, that every possible step has been taken to obtain the most efficient and economical operation not only of the prepayment plan itself but of the hospital as well, consistent, of course, with high standards of care and adequate levels of insurance protection. Just as the community hospital is a public service agency, the prepayment plan is a public service agency. In this rôle the prepayment plan must serve the public and the hospital equally well and be responsive to the needs of both.

The next step in making prepayment the primary method for allocation of consumer income to hospital care is to bring to every household an understanding of prepayment and why it costs what it does. An increase in the monthly cost of prepayment is a signal to every hospital trustee, every hospital employe, community agency, and civic group—using every community medium for dissemination of information—to inform the public of the meaning of prepayment. Rate increases should mean an increase in per-

new!

Davis & Geck **Aureomycin DRESSING**

An important advance in wound therapy

Aureomycin Dressing is an entirely new non adherent dressing with antibiotic action having the following advantages:

1. *Broad-spectrum.* It concentrates locally the antibiotic now recognized as the most versatile yet discovered with a wider range of activity against both Gram-positive and Gram-negative micro-organisms than any other remedy.
2. *Prevents infection.* It suppresses growth of many organisms which might be present in the wound or later contaminate it.
3. *Non-adherent and non-macerating.* Minimizes abrasion of healing wounds and avoids trapping of moisture conducive to bacterial growth.
4. *Promotes healing.* When infection is controlled healing takes place faster.
5. *Non-toxic.* Reactions to Aureomycin Dressing so far have not been observed.

◀ *also new Aureomycin* **PACKING** For use wherever plain or chemically impregnated packing was formerly used.

Description:

Aureomycin Dressing is an 8" x 12" gauze dressing of close mesh impregnated with 16 Gms. of 2% aureomycin hydrochloride ointment.

Aureomycin Packing is double selvage-edge gauze, in ½" x 24", 1" x 36" and 2" x 36" strips.

Available through D&G's surgical supply dealers

Davis & Geck, Inc.

a unit of American Cyanamid Company

Willoughby Street Brooklyn 1, N.Y.

Surgeons agree on D&G.

sons covered and broader benefits; not a decrease in coverage or a drop in benefit standards. As long as increases in cost of prepayment mean more and better services to the public, economically provided, they mean that prepayment has become more essential for every family, regardless of income, and has, likewise, become more important to the hospital and the entire community.

In an expanding economy and in a period of higher prices, progress toward improvement in prepayment plans and toward more extensive use of prepayment as the basic instrument for allocation of consumer incomes to hospital care, the underlying purpose is defeated if benefits are reduced as pressure for rate increases accumulate. To reduce benefits is a regressive step.

America, with respect to standard of living, is geared to progressive increases, not regression. This thinking is applicable to health services just as it is applicable to housing and other standard-of-living elements. Prepayment administration must reflect this philosophy if it is to be, in the end, successful.

If prepayment benefit standards are to be maintained or raised the public must know and understand the place of the hospital in community and family life and know also why hospital costs and costs of prepayment have risen faster than the cost of living and why they may continue to rise faster. The story told the public must not stop here. The public must also know that one in nine or 10 will be hospitalized this year, that the hospital bill in a typical industrial area will amount to an average of $150, and that in one out of 200 cases it will be more than $1000. Information of this kind, coupled with what hospitals and prepayment plans are doing to bring more service to the public for each dollar spent, will eliminate fear of rate increases and build public confidence and greater participation.

MUST CHOOSE OUR DIRECTION

Rapidly rising costs of prepayment have brought us to a fork in the road where a decision must be made as to the direction we will take from here. The choice is whether the courage out of which prepayment was born only a few years ago will again be the moving force to drive straight ahead to the original goal of making comprehensive prepaid hospital care generally accessible, or whether we take the temporarily easier route of retreat and regression toward lower benefits and fewer funds for financing hospital care. The first route calls for aggressive and intensive public education on the reasons prepaid hospital care is an essential consumer expenditure, while at the same time we give valid assurances that just as industry is constantly finding ways for increasing operating efficiency and improving quality, hospitals and physicians and prepayment plans are working in the public interest toward the same ends in the provision of health services. There can be only one decision at this fork in the road, but this decision does not lead to an easy route.

Belief in the concept that democracy exists for the sake of better living will furnish the motivation, and the results will be the reward. The ultimate decision to bring prepayment into the life of every American, just as the telephone, the automobile and electric lights are being brought to every home, rests with the consumer, but only the health and allied groups have the information and can provide the leadership for this public policy decision.

Conducted by Robert F. Brown, M.D.

Effective control of PHARMACY INVENTORY

covers every phase from purchase to consumption

HANS S. HANSEN
Administrator, Grant Hospital, Chicago

IT IS becoming more and more important to effect economies in the operation of hospitals. Because rising costs and the shrinking charity dollar necessitate a search for economies that will show savings but still not lower the standards of patient care, the administrator, among other items, must not overlook the hospital pharmacy inventory and a possible reduction in dollar investment in that department.

Governmental agencies and others have estimated that an inventory of $25 per patient bed is sufficient to enable the hospital to render adequate pharmaceutical service as to quantities and varieties.*

However, this estimate was made before the introduction of many expensive antibiotics and endocrines, such as cortisone and ACTH. These drugs have replaced certain items so there has been some reduction but probably it is not comparable in dollar volume.

CAN PREVENT DUPLICATION

It is as important to control items to be added to the pharmacy inventory as it is to control the items stocked; therefore, a hospital formulary is essential. Properly used, the formulary can prevent duplication of pharmaceuticals, which is the major cause of the dollar increase in inventories.

A control plan, to be effective, should cover every phase of the transaction, from the purchase to consumption. To achieve such control, it is necessary that each phase, from order to inventory, be carried out by using certain forms and records. In this manner, every item controlled can be traced at any time. The word "control" implies supervision as well as different individuals' checking the transactions throughout the entire cycle. By this means, errors as well as pilfering can be avoided. The following presentation of the flow of an item through the various steps may clarify and possibly aid in the installation of such a system.

The pharmacist requisitions the item required from the purchasing department on a general stores requisition form. (The pharmacist, being legally as well as morally responsible for items he dispenses, must have the right to complete the specifications.) The purchasing agent must not buy pharmaceuticals on the basis of price alone; to do so would jeopardize the pharmacist's position in the eyes of the medical profession.

The second step in the transaction originates in the purchasing department. The purchase order is written in triplicate; the supplier receives the original, the second copy is sent to the accounting department, and the third to the pharmacy.

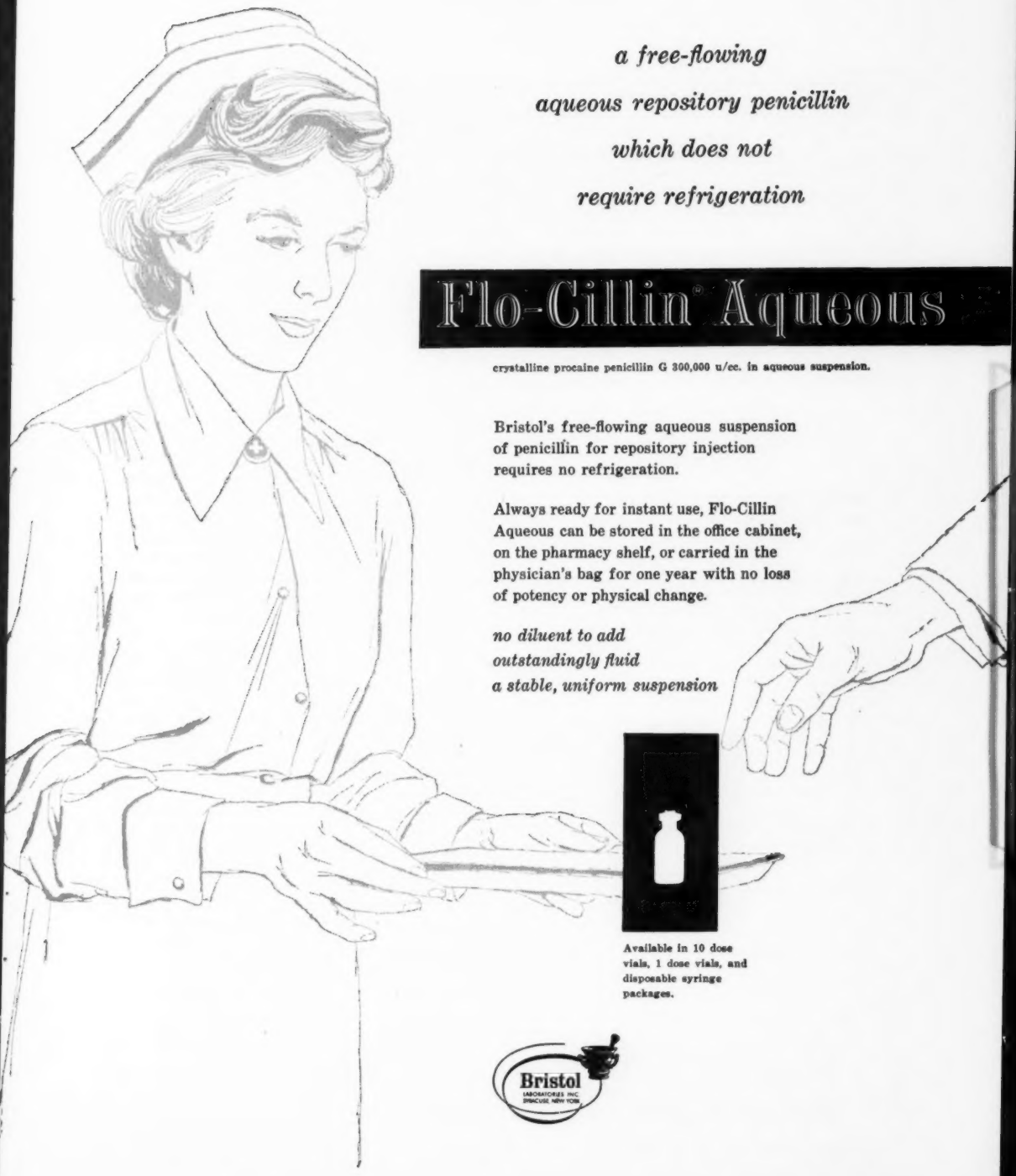
When the item is received, the third step is carried out by the storeroom clerk, who makes out a receiving form. This receiving form, in duplicate, is used in checking the invoice when it is received. One copy of the form is attached to the invoice; the duplicate remains in the storeroom for reference. The invoice is then sent to the pharmacy where the item is marked and entered on a perpetual inventory form. This concludes the fourth step in the procedure.

SAVE ORIGINAL COPY

The fifth step involves the accounting department. When the invoice arrives here, the purchase order is attached to it. In the pharmacy, at the end of each day, any item dispensed is deducted from the total on the perpetual inventory form. The pharmacist can establish the validity of this transaction by saving the original copy of the floor order form on which drugs are ordered for patients.

To complete the cycle, the semiannual or annual inventory should be taken by an outside firm which is experienced in dealing with pharmaceuticals. I have always questioned the value of a perpetual inventory control on all pharmaceuticals when considered from the standpoint of cost in man-hour time, but in view of the high cost of many pharmaceuticals, some control should be maintained. The items to be brought under control should be determined on the basis of

*Hansen, H. S.: Hospital Pharmacy—An Outline for the Administrator, Bull. Am. Soc. Hosp. Pharm. 4:55 (March-April) 1947.



a free-flowing
aqueous repository penicillin
which does not
require refrigeration

Flo-Cillin® Aqueous

crystalline procaine penicillin G 300,000 u/cc. in aqueous suspension.

Bristol's free-flowing aqueous suspension of penicillin for repository injection requires no refrigeration.

Always ready for instant use, Flo-Cillin Aqueous can be stored in the office cabinet, on the pharmacy shelf, or carried in the physician's bag for one year with no loss of potency or physical change.

no diluent to add
outstandingly fluid
a stable, uniform suspension

Available in 10 dose vials, 1 dose vials, and disposable syringe packages.

Bristol
LABORATORIES INC.
SYRACUSE, NEW YORK

GENERAL STORES REQUISITION

REQUISITION NO. ____

DATE ORDERED ____ 19__

DATE REQUIRED ____ 19__

DEPARTMENT ____ P.R. NO. ____

DO NOT WRITE IN SPACE BELOW

FORM NUMBER, SIZE, ETC.	DESCRIPTION OF SUPPLIES	WANTED	ACCOUNT NO.	DELIVERED	PRICE	PER	AMOUNT	ACCOUNT NO.

NON INVENTORY ITEMS ONLY { MFGR. ____ ADDRESS ____ CITY ____

REQUESTED BY ____

APPROVED BY ____

RECEIVED BY ____

FORM 801A 8-51 5M

Grant Hospital of Chicago

533-559 GRANT PLACE
Near Lincoln and Webster Aves.
Telephone Diversey 8-6400

PURCHASE ORDER

→ Order Nº 7143

IMPORTANT No delivery Accepted Unless Our Order Number is shown on Invoices, Packages, and on all Correspondence.

DATE ____ 19__

ORDERED FROM ____

Terms: CASH DISCOUNT ____ % ____ Days; Net ____ Days; F. O. B.

DELIVERY INSTRUCTIONS—All merchandise must be delivered to the receiving room in court east of corner Lincoln and Webster Aves. between 8:30 A.M. and 4:30 P.M. —Saturday 8:30 A.M. to 12:00 M. We will not be responsible for deliveries made at any other time or to any other departments.

QUANTITY	ARTICLES		PRICE	PER	AMOUNT

Approved By:

Administrator ____ Purchasing Agent ____

TO VENDOR—Please note that acceptance, delivery and payment are subject to the following regulations and instructions:—

1. Delivery Ticket and Packing Slip must accompany deliveries.
2. Shipments should be billed so as to include INSIDE STORE-DOOR DELIVERY. All shipping charges are to be prepaid unless otherwise specified on this order.
3. An itemized statement of account is requested immediately after the 1st of each month as it will facilitate payment of your charges.

PHARMACY

Nº 178361

Room No. ____

Patient ____ Date ____

If out-patient Address ____ Phone ____

	CHARGE	CRED'T

DR. ____ Registry No. ____

Nº 178361

Date ____

CASH RECEIPT
GRANT HOSPITAL
Chicago 14, Illinois

RECEIVED the sum of

$ ____

By ____

Above: First step in the control system is the requisition from the purchasing department of items required by the pharmacist. Center: The purchase order is written in triplicate; one copy goes to the supplier, the second to the accounting department, and the third is kept in pharmacy. Below: Floor order form.

a set unit price. That is, we could arbitrarily establish control over all items costing, say, $1 per unit or more. A unit may be defined as one dose or a multiple dose dispensed to the patient at one time. It would exclude 1 ounce, ¼ pound or 1 pound units of drugs or chemicals used in compounding prescriptions.

While this control plan can be established by various methods at any time, it would be simplest to institute it at an inventory period. Another method would be to take an inventory of all items to be controlled; a third, which is the least desirable, would be to place these items on control as ordered. This last method would require considerable time to institute.

The ever increasing number of pharmaceuticals, most of them expensive, that are being added to the physician's armamentarium, require that some plan such as the one outlined should be instituted in all hospital pharmacies. I do not intend to infer that this is the only procedure that could be used, but I do insist that some plan of control should be devised and put into practice.

Prepared by the Committee on Pharmacy and Therapeutics
University of Illinois College of Medicine, Chicago 12

Modern Antimalarial Therapy

WHEN our source of quinine was abruptly shut off during the war the study of old and new synthetic drugs was feverishly redoubled. Synthetic quinine was never seriously considered because of the complexity of the structural formula and the almost insurmountable obstacle presented by the fact that the quinine molecule contains four asymmetric carbon atoms which in any ordinary synthesis would result in 16 optical isomers. Yet another deterrent to the synthesis of quinine was the discovery early in the war that for military purposes atabrine (Quinacrine, U.S.P.) is a more effective antimalarial drug than is quinine.

Early in the war the chemists and pharmacologists were assigned the task of carefully and minutely comparing the American-made atabrine with the product of German manufacture. The drug was identical and was shown by the pharmacologists to be no more toxic to the experimental animal. In this country Shannon, working at Goldwater Memorial Hospital, proved by means of comparative therapeutic and toxic plasma levels of both quinine and atabrine that the latter is approximately four times as effective as quinine in the treatment of artificially induced malaria of the human patient or volunteer.

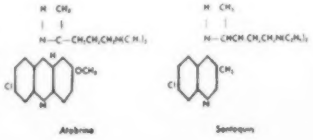
Meanwhile, Brigadier Fairley of the Australian Army, working at Cairns, Australia, with volunteer human subjects, showed conclusively that neither quinine nor atabrine would act *prophylactically* against sporozoite-induced malaria. They showed that for a period of from one to seven minutes after the bite of an infected mosquito the sporozoites circulated in the peripheral blood. Thereafter, the blood stream was devoid of malarial parasites until the seventh to tenth day after the mosquito's bite. At this time a mild parasitemia (Trophozoites), in spite of massive and continued doses of either quinine or atabrine, occurred with both vivax and falciparum strains. The parasitemia was not sufficient to produce clinical symptoms of malaria, but the parasitemia was easily demonstrable by thick smear studies or transfer to human volunteers.

Subsequent observation of these volunteers disclosed that those infected with P. falciparum were cured while those infected with P. vivax would regularly relapse from four to five weeks after the termination of atabrine therapy, or from one to two weeks after discontinuation of quinine.

Since the word *prophylaxis* means the prevention of malaria, and whereas subclinical malaria routinely occurs in spite of atabrine or chloroquin, a better term than prophylaxis for this drug effect is *suppressive therapy*. This term is now applied to this phenomenon.

Fairley also showed that with a dose of 100 mgm. (gr. 1½) per day of atabrine, blood loss, excessive sweating, extreme fatigue and multiple inoculations of sporozoites of both vivax and falciparum would not produce clinical symptoms of malaria although a mild subclinical parasitemia occurred from seven to 10 days after the bite of a malarial infected mosquito.

Early in the war, research efforts were directed toward drugs which might be *true causal prophylactics* by a direct lethal action on the sporozoites. In 1943 the program was changed by the capture of some white pills from the Germans in the Tunisian campaign in Africa. These were assayed, both chemically and pharmacologically, and were found to contain a potent antimalarial bearing the relationship to atabrine shown in the formula.



A study of new synthetic derivatives of this 4-aminoquinoline type soon disclosed that the compound without the methyl group in the 3 position was slightly more potent as an antimalarial than is sontoquin. This compound has been named chloroquin and is now available for general use. Chloroquin, like sontoquin, is a white powder and does not stain the skin yellow. In overdosage the drug produces blurring of vision, inability to focus the eyes rapidly, occasional bleaching of the hair and pruritus, and rarely, a lichen planus-like skin lesion.

One of the most marked improvements, in contrast to atabrine, is the lack of gastrointestinal irritation which is sufficiently reduced so that a single dose of 500 mgm. of chloroquin taken once a week will provide adequate suppressive therapy against both vivax and falciparum malaria.

A clinical estimation by Shannon of the antimalarial index after oral dosage in man gives the following indices where the effect of quinine is arbitrarily set at unity; atabrine four times, sontoquin eight times, and chloroquin 12 times as effective as quinine. Thus, the new antimalarials, if considered only on a basis of suppressive therapy, are distinctly superior to quinine.

The British workers have also produced an effective antimalarial drug as a result of their war research. They have literally opened the quinoline molecule and found a simple chlorphenyl derivative which is apparentiy as active and nontoxic for suppressive therapy as is chloroquin. It has the following structural formula and is known as paludrine. It compares favorably with chloroquin in both lack of toxicity and antimalarial activity:

Bacterial count per cc.

2000

average count after soap and water washing (1,937)

70-second wash with *Bactine* (20% solution) causes rapid drop in bacterial count

1500

1000

500

prolonged action of *Bactine*—bacterial counts at various intervals after *Bactine* wash

RAPID

PROLONGED

1/4 hrs.

4 1/4 hrs.

5 3/4 hrs.

1 2 3 4 5

Time (hours)

Rapid and prolonged disinfection

for skin preparation

for disinfectant hand prep

Bactine

BRAND · Reg. U. S. Pat. Off.

Here is evidence of the powerful and prolonged antibacterial action of ***Bactine*** that has given it an important place in the operating room and in the physician's office:

rapid, prolonged disinfection of hands with Bactine

(Subjects carried on usual activities involving recontamination during test)

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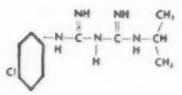
B-15

MILES LABORATORIES, INC. ELKHART, INDIANA, U. S. A.

Chemotherapeutic Effect of Antimalarials

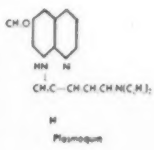
Type of Action:	Prophylactic	Suppressive Therapy	Curative in Vivax	Transmission Prophylactic
Acts on:	Sporozoite	Trophozoite	Exoerythrocytic Form	Gametocyte
Drugs:	Chlorguanide Sulfa Drugs	Atabrine Quinine Chloroquin Chlorguanide	Quinine Plus Primaquine for 14 Days	Chlorguanide Daraprim

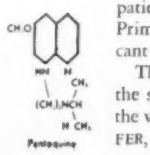


Chlorguanide, U.S.P., or paludrine, is of interest as an antimalarial because it has some true causal prophylactic effect against the wiggling sporozoite which the mosquito introduces into man's skin. In the usual suppressive therapeutic doses of 100 mgm./day, chlorguanide makes the gametocytes of human blood uninfective for the mosquito; therefore, from the standpoint of total eradication of malaria, chlorguanide has greater possibilities than the 4-aminoquinolines. Furthermore, chlorguanide is cyclicized in the body to phenyl-triazine (bi-ring system) which is the most potent antimalarial known. Compounds of this type may suppress malaria when given in doses as low as 5 mgm. per day.

Toward the close of the war the armed services and the investigators were faced with the problem of what to do with the numerous cases of relapsing vivax malaria which were accumulating in veterans' hospitals and in the various prisons where the inmates had volunteered for antimalarial research.

Pentaquine Therapy. Records obtained from the Germans after V-E Day disclosed that a definite percentage of relapsing vivax malarial cases could be cured by combined therapy with quinine and plasmoquin, an 8-amino substituted quinoline which had hitherto been considered too toxic for general use. Accordingly, a new and less toxic 8-aminoquinoline was synthesized. Pentaquine and plasmoquin have closely related structural formulas:





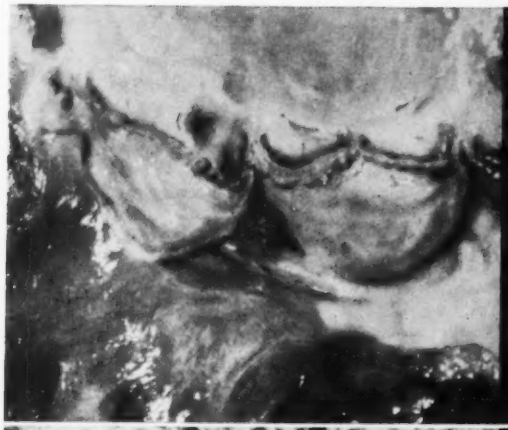
Because these drugs are likely to produce severe gastrointestinal upsets, methemoglobinemia, hemolytic anemia, hemoglobinuria and even acute yellow atrophy of the liver, they can be given only to hospitalized patients in small doses of 20 to 30 mg. T.I.D. for from seven to 10 days. At present, quinine is also given simultaneously inasmuch as the available data show a higher percentage of cures with this combination therapy. It is known that combined atabrine therapy increases the toxicity of plasmoquin by increasing the hemolytic effect on red blood cells. The Negro and other dark skinned races are more susceptible to this hemolytic effect of the 8-aminoquinolines and thus only one-half to three-fourths of the usual dose is used in Negroes. However, for vivax infections this combination is curative and therefore, despite the toxic reactions, patients with tropical strains of vivax must frequently be hospitalized and given the treatment to prevent continuous relapses.

Primaquine (S.N. 13-272) is the latest 8-aminoquinoline to be tested, in animals, by Schmidt and, clinically, by Alving and his co-workers. It differs from plasmoquin only in that the aliphatic amine is not substituted. Clinical testing shows that 22.5 mgm. of primaquine base with 1.64 Gm. of quinine base given daily in six divided doses for 14 days will cure 100 per cent of heavily infected patients. Fifteen mgm. of primaquine base can be given safely each day without medical supervision. If given for 14 days, this dose will cure most field infections, including vivax malaria acquired in Korea.

Pentaquine given with quinine will only cure about 70 per cent of heavily infected patients and some of these patients will have toxic symptoms. Primaquine thus constitutes a significant advance in the *cure* of malaria.

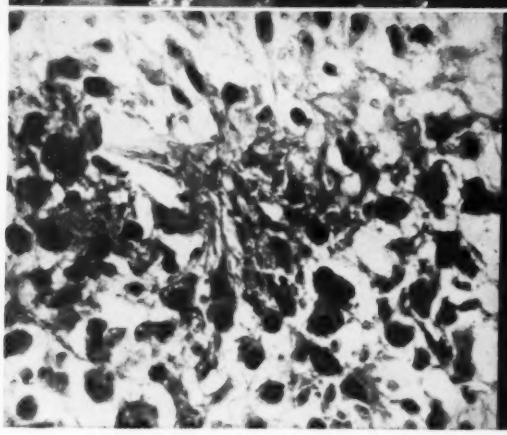
The accompanying table summarizes the specific chemotherapeutic effect of the various antimalarials.—C. C. PFEIFFER, PH.D., M.D.

response in rheumatic fever



q. Does cortisone influence the heart lesions of rheumatic fever?

a. Early cortisone administration suppresses and in some cases may even prevent serious cardiac damage.



q. What effect does cortisone have on acute rheumatic fever?

a. Often within 24 hours after cortisone therapy, the severely ill, toxic patient appears alert and comfortable; and within one to four days, temperature drops to normal, appetite increases, and polyarthritis subsides.

Cortisone Upjohn

available as compressed tablets Cortisone Acetate, 25 mg., for oral use. Bottles of 20 tablets.

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Causes of Cross-Infection

IN a special article, "Cross-Infection in Hospital Wards," published by the *Lancet*, April 19, 1952, J. W. D. Goodall, M.D., exposes some of the appalling and archaic practices which still flourish in many hospital wards, and which undoubtedly account for the high incidence of cross-infections among patients and hospital personnel.

This study is based on data accumulated over a period of one year from 13 wards in eight hospitals covering 5095 patients, 178 nurses, and 45 doctors. Although the over-all incidence of cross-infection for all patient wards was 9.9 per cent, the highest rates of infection were 21 per cent in a children's ward, 19 per cent in a neurosurgery ward, 18 per cent in a plastic surgery ward, and 15 per cent in a thoracic surgery ward. The most frequent infections contracted in children's wards were the common cold and upper respiratory diseases; in maternity wards, urinary and puerperal infections; among babies, impetigo and conjunctivitis, and, in special surgical wards, infected wounds, pneumonia and respiratory diseases. The depressing result of these acquired infections was an average increase of 21 days of additional hospitalization per infected patient. In a thoracic ward the estimated increase was as high as 60 days. No data are given as to the time lost resulting from infections among nurses and doctors.

In an effort to track down the etiologic factors responsible for cross-infections in hospital wards, Dr. Goodall undertook the study of physical layouts; facilities for bathing, washing, sterilizing of instruments; handling of food and linens, and housekeeping methods. He spent considerable time covering 24 wards in 13 hospitals, including the 13 wards where the infections were analyzed.

His findings proved that no satisfactory technics had been employed to prevent cross-infections, and that the many published recommendations by research, pediatric and health organizations had been ignored. He found most wards too crowded. No proper or adequate facilities had been provided for nurses to wash their hands. No instruction was given to the domestic help in the rudimentary principles of hygiene. Dishes were being washed in one sink, with no facilities for sterilization. Great numbers of coliform bacilli and staphylococci were counted in cups and on plates, spoons and forks. Drying towels were heavily contaminated. Most wound dressings were done on the open wards instead of in treatment rooms—the windows at times open, at times closed! Bathrooms and water closets mostly opened off the utility rooms, and the proportion of tubs and toilets to patients was usually inadequate. Utility rooms were badly designed, clean and dirty work being done side by side, and congested with medical supplies and apparatus.

DOCTORS DO WEAR MASKS

Linens were counted, sorted, recounted and sometimes rinsed in the utility rooms before being sent to the laundry—a dangerous and antiquated practice. Floors were dry swept with a broom two to three times a day and scrubbed once every three months.

Refrigerators for perishable foods, such as milk and butter, also were used to store penicillin, blood, skin and cartilage and pathological specimens. Disinfectants for thermometers were changed once a week, and some every fortnight—or when someone remembered. Autoclaves were usually old, located in the basement, and operated by a porter. In most wards, syringes were sterilized in alcohol instead of being autoclaved. However, to brighten this dismal picture, it is gratifying to learn that doctors used masks on most wards, even while changing dressings, doing catheterizations, blood transfusions and setting up saline drips.

Dr. Goodall rightly disapproves and condemns these practices and recommends the formation of a committee in each hospital to initiate changes, institute improvements and promote educational programs for hospital personnel.—S. W. FRIEDMAN, D.D.S., *assistant director, Montefiore Hospital, New York City.*

Two members of the staff of the Mt. Vernon Hospital, Mt. Vernon, N. Y., are shown as their questions are being answered by a professional service representative of Ciba.

E. Weisberger, Superintendent, Cedars of Lebanon Hospital, Los Angeles, Calif., with a Ciba Educational Exhibit in a corner of the staff room.

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Food Service in Small Hospitals

I. MENU PLANNING

ROSALIND C. LIFQUIST
Food Economist
Bureau of Human Nutrition
and Home Economics
U.S. Department of Agriculture

JANE HARTMAN
Food Service Director
Maryland State Department of Health
Baltimore

DO YOU, as an administrator of a small institution serving 200 persons or fewer, give serious consideration to the importance of your dietary department? Do you realize how big a business this department represents as shown by the cost of its operation in relation to total expenditures of the institution?

Usually the cost of running a dietary department is the largest single item of expense and represents from one-fourth to one-third of the total expenditures of the institution. Often, little is known about this expenditure of money.

QUESTIONS TO BE ANSWERED

Perhaps the only information at hand might be that the food cost $1500 this month and $1200 last month. Such figures alone won't tell why the food bill is more this month than last. Nor will they answer such questions as: "Was the increased cost due to a rise in prices?" "Was it a result of using more expensive foods?" "Was it because the quantities used per person per day were increased?" "Was it because more people were fed?" "Was the food nutritionally adequate?"

Do you, as an administrator, give serious consideration to the quality of the food as it finally reaches the people for whom it is intended? Do you appreciate the public relations value of good food? Does your institution have a reputation for good or poor meals? If for good meals, how was this accomplished? Is it only because the person in charge of the dietary department is permitted to spend as much as she wishes just so the food is satisfactory? Are you getting good food by paying premium prices? If you have too many complaints about the food, have you found the causes?

If you have given serious consideration to your dietary department, you know that it plays an important rôle in a well run institution. Moreover, you are aware that the person in charge has a vital and a responsible job to do—a job that calls for more skills than just being a good cook. While knowing how to prepare good food is a major part of food service, it is a big order to expect persons, with little or no professional training or experience, to be responsible for managing the entire dietary service without some guidance.

The shortage of dietitians has placed many persons without special training in such positions. These persons should have training and an administrator may wonder what to do about it.

In some cases, several small institutions employ one dietitian to act as a consultant for all, spending some time at each institution. Dietitians who are living in the community and not currently employed often are willing to work part time. Where these services are not available, dietitians employed in other local institutions sometimes will help out.

Many states have initiated programs to provide guidance to these dietary supervisors by employing nutritionists who are available upon request to give aid. A recent survey made under the sponsorship of the community nutrition section of the American Dietetic Association* showed that 12 state departments of public health were employing full-time dietitians to act as consultants to small institutions. In 22 other states, limited services were offered. Assistance was given through materials prepared for use by dietary supervisors. When possible, these dietitians and nutritionists visited institutions and suggested ways for improving the management of the food service. Often institutes were held at which problems were discussed.

However, in spite of these opportunities, there still remain some dietary supervisors who are unable to obtain any guidance. What can be done to help these people?

The survey previously mentioned stated that the greatest number of requests were for help in planning menus. Other requests were for methods that can be used to evaluate menus for nutritional adequacy, recipes, suggestions for serving food, aids to better purchasing, and employe training.

To help these supervisors, as well as administrators, a series of four articles has been developed that deals with some of these major problems. This article concerns menu planning while those that are to follow will discuss food preparation and service, nutritional and cost accounting, and employe supervision and training.

MENU PLANNING

Why is menu planning such a problem? Meals are constantly recurring events. One meal is hardly served before the next is in the offing. Many persons must be satisfied, each of whom has his own ideas on what constitutes a good meal. Equipment may be inadequate and there may be

*Jones, M. C.: Dietary Consultation—a Service for Small Institutions. J. Am. Diet. A. 26: 650-53. (September) 1950.

a shortage of employes. Frequently food purchasing problems arise. Fresh produce may not be readily available. Wholesale markets may be in distant cities, necessitating the purchase of some food at retail prices. Limited storage space may further complicate the management of food supplies.

What can a dietary supervisor do to make it easier? Meals are combinations of individual foods. It is getting suggestions for these individual foods that is the hard part of menu planning. A good collection of recipes will help to provide ideas as well as directions for carrying them out. The first step in menu planning, therefore, is to acquire a collection of suitable standardized recipes.

Many tested recipes for quantity use are available free and others may be obtained at moderate cost. In addition, many state colleges, universities and commercial companies have home economics departments that develop recipes which often are available upon request.

How can you select "suitable recipes?" The following points should be considered in choosing the recipes to include in your file:

1. Select recipes for the kind of food that can be prepared with the equipment you have. No matter how good a recipe is, if it calls for a power mixer and gives directions in terms of minutes of mixing at a specified speed, it will be of no value if you haven't a mixer.

2. Select simple recipes that do not require too much time to prepare—more time, that is, than is possible with the number of employes you have.

3. Select recipes for the kinds of foods that are well liked as well as suitable for the residents of the institution. Plain, well cooked and attractively served foods usually are more acceptable than too many fancy or mixed foods.

Foods used in a children's home will be somewhat different from those in institutions for adults. If one menu must serve different age groups, simply cooked foods are the wisest choice.

4. Accumulate several different recipes for popular dishes, especially main dishes. For example, meat loaf can be served plain, with tomatoes mixed in with the meat, with tomato or cream of mushroom sauce served with it, or with hard-cooked eggs placed in the center before the meat loaf is baked.

Illustration 1—Method for Estimating Cost of Recipe

Meat Loaf			*Portion: 4 ounces*
	100 Portions	*Cost per Unit*[1]	*Cost*
Beef, ground	16 pounds	$0.680 per pound	$10.880
Pork, ground	5 pounds	0.440 per pound	2.200
Salt	½ cup	0.015 per pound	0.005
Onion, chopped	1½ cups	0.120 per pound	0.060
Bread crumbs, coarse, dry	1½ gallons	0.140 per pound	0.700
Eggs, beaten	10	0.510 per dozen	0.425
Milk	1½ quarts	0.220 per quart	0.330
Tomato juice	1½ quarts	0.508 per No. 10 Can	0.254
Total cost of recipe			$14.854
Cost per portion			0.1485

[1]March 1952 prices.

5. Select recipes that are not too expensive. Using current prices, estimate the cost per serving by first figuring the total cost of the ingredients called for in the recipe and then dividing this total cost by the number of portions that can be obtained from the recipe. See Illustration 1.

6. Test the recipe by having the cook follow the quantities and directions exactly. There should be no haphazard adding of extra ingredients to "make it better." It may make it worse instead.

7. Check acceptability of the recipe by serving the food first to only one group of residents. Is it well liked? If not, why not? Is it because it is new to them or because the recipe is not good? Is it because they prefer the food served in another way? For example, in one institution when rice was served in place of potatoes, two-thirds of the rice was thrown away. Yet these same residents who refused it enjoyed rice and raisin pudding.

8. Serve the amount designated on the recipe as the portion size. Check the number of portions actually obtained and compare with the number stated.

9. Figure the quantities needed to serve all the residents if the food was well accepted by the test group. Keep the recipe in your working file for later use.

10. Check the acceptability of the dish again, when served to all the residents.

In developing a recipe file, start by collecting recipes for main dishes. Then select those for the other parts of the menu—soups, vegetables, salads, desserts. Even when the file appears complete, add new recipes from time to time and discard those no longer popular. Then make the file help you with your planning.

How can a recipe file help in menu planning? A good recipe file will provide ideas for foods that represent each component of an institution's "meal pattern." A meal pattern is a design indicating the types of food that are to be included in each meal of the day. Patterns in common use in many institutions are similar to the following:

Breakfast	Lunch or Supper	Dinner
Fruit	Main dish	Main dish
Cereal	Vegetable or salad	Vegetables (two or three or salad in place of one vegetable)
Main dish	Bread-spread	
Bread-spread	Fruit or dessert	Bread-spread
Beverage	Beverage	Dessert
		Beverage

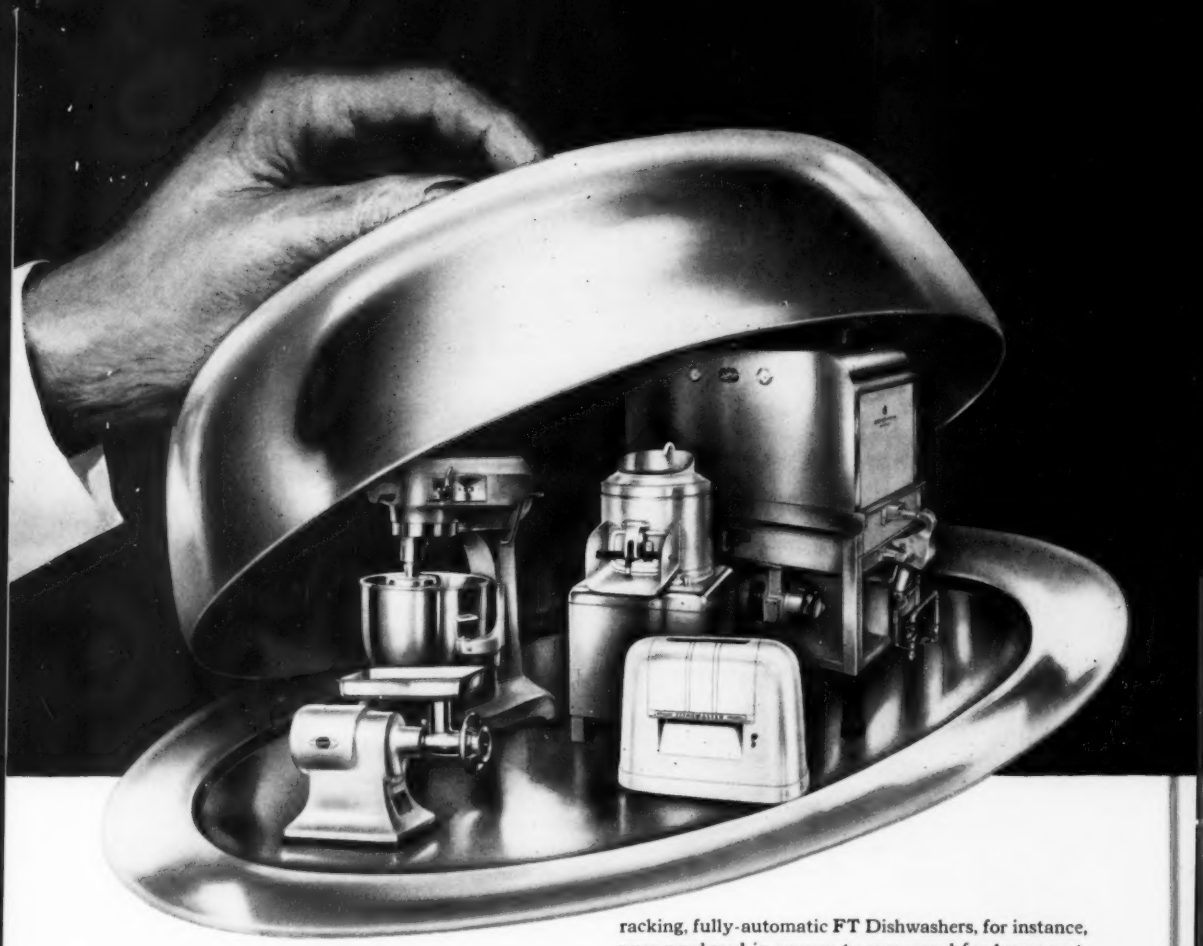
The chief difference in meal patterns among institutions is in the number of food items included. In general, when an institution must operate on a low-cost budget, fewer items are included and the serving of each is somewhat larger than when there is more money to spend.

Perhaps the best way to make your recipes work for you in menu planning is to list them according to their use in different meals. Illustration 2 shows how to do this.

In this chart, the components of the meal pattern become headings for the columns. A chart is used for each meal—dinner, breakfast, lunch or supper.

The name of each recipe in the file is listed under the proper heading. Other foods that are purchased, "ready-to-serve," such as various kinds of breads and cereals, also should be included in the proper columns.

To assure variety, have a set of charts for each season. Some foods may be included for year-round use,



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others only during one particular season. If certain foods and dishes are not served continuously month after month, they generally are welcomed when reintroduced.

Use these charts as a reminder when is is time to plan your menus. Then check off on the charts the foods you have used, as shown in Illustration 2. The next time it will be evident which foods are being overworked and will bring to mind others that are equally acceptable.

Checking the kind and cost of food currently on the market is a "must" and is helpful in menu planning. Get on the mailing list of wholesale markets for their weekly price list of foods.

Other sources of ideas can come from residents and employes. In small institutions, it may add interest to include one food each day that someone has requested. If you do this, give it a little publicity. It may help to show that you are trying to cooperate with the residents by serving food that is pleasing to their tastes.

For the important job of planning menus, set aside a definite time and a definite place. It may even help to be hungry!

Menus should be planned and written down at least a week in advance. Advance planning permits checking menus for nutritional adequacy as well as for variety. It helps in planning for purchase needs, and certainly it helps the cook to plan her work more efficiently.

A form that is widely used to write down menus is shown in Illustration 3.

In setting up a week's menus, many supervisors prefer to start by selecting the main dish for the dinner meals. They continue by selecting the other foods to complete the meals. For example, roast shoulder of pork may be chosen for a main dish and, to go with it, sweet potatoes, broccoli, rolls, butter or margarine, baked apples, and a beverage.

Breakfast usually is planned next as this meal follows a fairly constant pattern.

Lunch or supper is planned last. This meal should include the kinds of foods needed to make the total of the day's food nutritionally adequate—to make up for any lack in the dinner or breakfast menus. While lunch or supper is often the least interesting meal and the most difficult one to plan, the job may be simplified by having on hand a collection of recipes especially selected for this purpose, such as casserole dishes which go well at this meal.

When choosing foods to go together in the same meal, follow the usual menu planning directions and include foods that provide variety in texture, flavor and color. Include a crisp, a firm and a soft food to guard against meals that are monotonous in texture.

Several highly seasoned foods should not be combined in one meal. Serving flavorful foods with milder ones, a bland food with a relish or sauce that is optional, is usually more acceptable.

Foods that make attractive color combinations tend to stimulate the appetite. One bright colored food should be included in each meal.

Include a food with staying quality, one that gives a satisfied feeling so that an individual isn't hungry soon after the meal is over. For example, a person might be hungry soon after a low-protein meal consisting of bouillon, cabbage and apple salad, a roll and tea.

Avoid serving too many canned vegetables or fruit in any one day.

Try to have only one item in a meal that is time consuming to prepare. Keep other foods in the meal simple and easy to prepare.

Do not have too many foods on the same menu that require last minute preparation, for example, sautéed liver, whipped potatoes, spinach and hot biscuits.

Combine cheaper foods (in recipes and meals) with the more expensive ones to keep costs from getting out of line. When you have one of the more expensive cuts of meat, use a less expensive vegetable and dessert; use a more expensive vegetable with a cheaper cut of meat. Thus, the high cost of one is often counterbalanced by the other, and the general effect is of a special treat owing to the use of a single "luxury" item.

When menus are completed, picture how the whole meal will look on dishes used at the institution. Attractiveness of food, color harmony and contrast have a good effect on the reaction of people to meals. This, incidentally, is an important fact to keep in mind when you select dishes

Illustration 2—Suggested Form for Listing Foods Suitable for Dinner Menus[1]

DINNER

Main Dish	*Number of Times Served*	*Potatoes*	*Number of Times Served*	*Vegetables Cooked*	*Number of Times Served*	*Salads*	*Number of Times Served*	*Breads*	*Number of Times Served*	*Desserts*	*Number of Times Served*
Beef		*White*		*Carrots*		*Cabbage*		*Bread*		*Cake*	
Roast.....	II	Baked.....	I	Buttered.....	IIII	Coleslaw.....	I	Enriched.....	IIIIIII	Plain, white...	II
Swiss steak...	I	Whipped....	IIIII	Panned.....		Cabbage and apple.....		Whole wheat.		Chocolate....	
Stuffed flank steak.....		Escalloped ...		Creamed.....		Cabbage and carrot.....		Raisin.....		Gingerbread .	II
Meat loaf....	IIII	Creamed.....		Glazed.....		Cabbage, carrot and raisin.....		Oatmeal.....		Dutch apple..	
Spanish meat balls..		au gratin.....		Carrots O'Brien....		Cabbage and green pepper....		Rye.....		*Cookies*	
Browned beef stew.....		Potato cakes.....	I	Escalloped...		Cabbage and tomato.....		*Rolls, all kinds*		Molasses.....	
Corned beef..		Potato puff.....		Timbales.....				*Muffins*		Oatmeal.....	
Beef patties..		Boiled in jackets.....						Plain.....		*Puddings*	
Meat pie.....		Roast.....						Prune.....		Baked custard	I
Liver.....								Bacon.....		Cornstarch....	I
								Biscuits		*Pastry*	
								Baking-powder....		Cherry tarts..	I
								Butterscotch...		Pies.....	

[1]This chart is merely a suggested form and is not complete. For maximum usefulness, it should be extended to include all the foods normally used at your institution.

Here's *More Coffee Flavor*

There are many tastes to please in a hospital—nurses, patients, doctors, the administrative staff. In coffee *all* want FLAVOR. Millions enjoy Continental Coffee because it has the *most* in flavor—delicious, winey-rich, full-bodied and unvaryingly fine—kept so by special Automatic Roasting Controls that maintain exact uniformity.

These qualities of more flavor and uniformity, plus Continental's topnotch coffee service, all add up to *value*—value so highly regarded that nearly 21,000 hospitals, restaurants, hotels, and other dining places prefer and serve Continental Coffee today!

For more coffee flavor in your hospital, for more coffee enjoyment and *better value*, see your Continental Man, now!

For best results regardless of brand—always brew your coffee 2½ gallons to the pound

In every walk of life everyone enjoys...

Continental Coffee

AMERICA'S LEADING COFFEE for RESTAURANTS, HOTELS and INSTITUTIONS

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GELATIN DESSERTS, with sugar—Low cost, very bland. Six wholesome fruity flavors. Sets fast, stands up due to high content of pure food gelatin.

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GELATIN, plain, unsweetened—quality approved by American Medical Association.

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SALAD DRESSINGS—Extra nutritious because rich in eggs and oils. High caloric content.

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SOUP MIXES—Deliciously seasoned to make rich, savory "Homemade" soups for about 1¢ per serving. Perfect as stock bases for meat dishes.

•

PURE EGG NOODLES and MACARONI and SPAGHETTI—High nutrition at notably low cost. Tender, firm, flavorful.

•

CONTINENTAL TEA—Better flavor because it is made only from tiny tender leaves.

•

HOT CHOCOLATE—Our own blend of fine cocoas and sweet milk powder.

•

CHOCOLATE SYRUP—Made in our own kitchens. A perennial favorite. Makes richer tasting desserts.

FREE RECIPES

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MAKERS OF CONTINENTALS FAMOUS "76" MENU PRODUCTS

Illustration 3—Menus[1] for the Week of _____

Menu Pattern	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Breakfast							
Fruit							
Cereal							
Main dish							
Bread-spread							
Beverage							
Dinner							
Main dish							
Vegetables (2 or 3 or salad in place of 1 vegetable)							
Bread-spread							
Dessert							
Beverage							
Lunch or Supper							
Main dish							
Vegetable or salad							
Bread-spread							
Fruit or dessert							
Beverage							

[1]Include citrus fruit at least once daily.
Include at each meal a crisp, a firm, and a soft food.
Include at least the following quantities of milk daily:
For children: 3 to 4 cups — For pregnant women: A little more than a quart
For adults: 3 cups — For nursing women: 6 cups
This includes milk used in cooking as well as a beverage. Cheese, cottage cheese, and milk in other forms can be counted as part of this quantity.

for your institution. Too brilliant or garish colors can conflict with the more delicate natural colors of foods.

Occasionally try to vary the kind of service; for example, plan a picnic or a buffet supper. Some institutions may find this difficult to do. Even so, employes welcome a change from routine now and then and may take an interest in helping to make it possible.

Remember such occasions as holidays and birthdays whenever possible. A portion cut from a sheet cake and covered with a quick uncooked white icing and topped with a small candle should delight anyone.

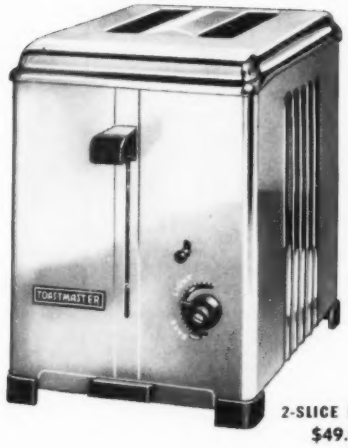
When these suggestions for variety in menus have been followed, meals probably will be nutritionally adequate. This should not be taken for granted, however, as it is extremely important that the food provide for the needs of the people for whom it is planned. The guide at right will be helpful in checking menus to make sure that they provide the right kinds of food.

Although a serving or portion may be an indefinite term, it should mean more than a garnish or a leaf of lettuce. For example, a serving of vegetables usually indicates about ½ cup; a serving of meat, the equivalent of about 3 or 4 ounces cooked, or ½ to ¾ cup of stew. A later article will discuss a technic for estimating more accurately the total quantity of food needed to provide nutritionally adequate meals.

	SERVINGS						
	S	M	Tu	W	Th	F	S
INCLUDE							
Leafy, green, and yellow vegetables: At least one serving daily							
Citrus fruit and tomatoes: At least one serving daily							
Potatoes, sweet potatoes: 1 or more servings daily							
Other vegetables and fruit: 1 or more servings daily. Or additional servings of leafy, green and yellow vegetables							
Milk, cheese, ice cream: Plan to use the following amounts each day: Children through teen-age: 3 to 4 cups. Adults: 3 cups. Pregnant women: A little more than a quart. Nursing women: 1½ quarts							
Meat, poultry, fish: 1 or more servings daily. Include liver or other variety meats once a week if possible. Additional servings of eggs may take place of some meat							
Eggs: 4 or more a week, or additional servings of meat, poultry, fish							
Dry beans, peas, nuts: 1 or more servings a week							
Flour, cereals and baked goods: Some enriched, whole grain, or restored cereals daily; others as needed for satisfying meals							
Fats and oils: Some butter or margarine daily, other fats as needed in cooking							
Sugar, sirups and preserves: As needed for energy and flavor in meals							

The second article in this series, planned to help the dietary supervisor in small institutions, deals with food preparation and service. It will appear in the September issue of this magazine.

It pays to put the **TOASTMASTER** *toaster in* FLOOR DIET KITCHENS!



2-SLICE MODEL
$49.00

More and more hospitals are supplementing their main-kitchen toasters with "Toastmaster" Toasters in floor diet kitchen service. Toast for each floor is made in the diet kitchen *on that floor*. So toast always reaches patients hot, fresh, and crisp. That adds appetite appeal, makes the entire meal more enjoyable, means a lot to patients.

Yes, and the time and steps this type of installation saves in toast-making mean a lot to hospital personnel. You'll like the "Toastmaster"* Toaster's completely automatic operation, the sturdiness of its construction, and the ease with which it makes light, dark or in-between toast—just the way each patient prefers it. All you do is dial the color of toast that's wanted.

The 2-slice "Toastmaster" Toaster (upper left) pops up 125 slices per hour; the four-slice (lower left) has an hourly capacity of over 250 slices. You buy the size you need now; then, as requirements grow, it's easy to add a unit that will satisfy any toasting needs —all the way up to 1000 slices of golden brown toast per hour.

4-SLICE MODEL
$94.00

TOASTMASTER
automatic POP-UP *TOASTERS*

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Your Food Service Equipment Dealer will be glad to show you all the advantages of the flexible, "put-it-where-you-need-it" "Toastmaster" Toaster. Call him now.

Menus for September 1952

Edith H. Dorman
Dietitian
Enloe Hospital
Chico, Calif.

1 Sliced Banana Bacon, Scrambled Eggs • Leg of Lamb, Mint Jelly Escalloped Potatoes Buttered Carrots Pears in Mint Gelatin Snow Pudding • Cream of Corn Soup Meat Loaf, Gravy Mashed Potatoes Escalloped Tomatoes Green Candied Apple Ring Peach Shortcake With Whipped Cream	**2** Applesauce Bacon, Poached Egg • Beef Broth, Mushrooms Baked Ham Mashed Potatoes Frozen Spinach, Lemon Molded Fruit Salad Lemon Sherbet • Tomato Bouillon Chicken à la King Steamed Rice Peas and Carrots Lettuce With French Dressing Green Gage Plums Applesauce Cake	**3** Prunes Bacon, Cinnamon Toast • Chicken Noodle Soup Roast Beef Browned Potato Harvard Beets Tossed Salad Bread Pudding With Fruit Sauce • Mulligatawny Soup Creamed Chipped Beef Escalloped Summer Squash Peach, Prune Salad Baked Apple With Whipped Cream Oatmeal Cookies	**4** Cantaloupe Bacon, Poached Egg • Beef Barley Soup Veal Birds Mashed Potatoes, Gravy Buttered Asparagus Tips Tomato Aspic on Lettuce Butterscotch Pudding • Split Pea Soup Beef Stew Steamed Potatoes Carrots and Celery Pineapple, Cottage Cheese Salad Date Cake With Whipped Cream	**5** Fresh Grapes Scrambled Eggs • Scotch Broth Halibut, Tartare Sauce Creamed Potatoes Sliced Tomatoes Lettuce Wedge With French Dressing Apple Tapioca • Vegetable Soup Salmon Puffs Steamed Rice Buttered Peas Stuffed Celery With Blue Cheese Lemon Cake	**6** Banana Bacon, Poached Egg • Cream of Corn Soup Meat Balls Mashed Potatoes, Gravy Buttered Beets, Lemon Lettuce, Peach Salad Pineapple Upside Down Cake • Cream of Mushroom Soup Roast Beef Mashed Potatoes, Gravy Mixed Frozen Vegetables Lettuce Wedge With 1000 Island Dressing Apricots
7 Melon Bacon, Soft Cooked Egg • Tomato Bouillon Turkey, Dressing Mashed Potatoes, Gravy Frozen Peas, Celery Cranberry Gelatin Ice Cream • Oxtail Soup Macaroni and Cheese Buttered Green Beans Carrot, Raisin Salad With Mayonnaise Cinnamon Cookies Royal Anne Cherries	**8** Grapefruit Sections Bacon, Poached Egg • Bouillon Roast Beef Mashed Potatoes, Gravy Buttered Yellow Squash Lettuce Wedge With French Dressing Fresh Blueberries, Cream • Cream of Vegetable Soup Meat Roly Poly With Mushroom Sauce Frozen Buttered Peas Fruit Salad Plate: Pear, Apricot, Peach, Pineapple Baked Caramel Custard	**9** Baked Rhubarb Sauce Bacon, Coffee Cake • Chicken Rice Soup Lamb Chop Creamed Potatoes Buttered Beets Lettuce Wedge With French Dressing Gingerbread With Nutmeg Sauce • Cream of Mushroom Soup Salmagundi Frozen Spinach, Egg Waldorf Salad Red Gelatin With Whipped Cream	**10** Crushed Pineapple Bacon, Poached Egg • Pepperpot Soup Stewed Chicken Homemade Noodles Candied Carrots Pear, Cottage Cheese Salad Watermelon Cubes • Bouillon Country-Fried Steak Baked Potato Buttered Celery Cranberry Relish Fresh Sliced Peaches	**11** Melon Bacon, Soft Cooked Egg • Chicken Noodle Soup Veal on Toast Mashed Potatoes Frozen Asparagus Pineapple, Prune Salad Custard Pudding • Cream of Corn Soup Boiled Tongue Steamed Potatoes Escalloped Zucchini Carrot, Olive Salad With Boiled Dressing Fresh Fruit Compote	**12** Figs Scrambled Eggs • Vegetable Soup Planked Salmon, Lemon Creamed Potatoes Buttered Wax Beans Tomato With French Dressing Fresh Grapes • Cream of Pea Soup Escalloped Eggs Double Baked Potatoes Sour Beets Lettuce With Peach and Cottage Cheese Chocolate Cake
13 Stewed Apricots Bacon, Poached Egg • Mulligatawny Soup Meat Loaf, Gravy Mashed Potatoes Escalloped Tomatoes Lettuce, Asparagus and Deviled Egg Salad Apple Dumpling, Sauce • Chicken Rice Soup Liver and Bacon Parsliied Potato Buttered Green Beans Endive Salad With French Dressing Fresh Strawberries	**14** Fresh Pears Bacon, Soft Cooked Egg • Bouillon Fried Chicken Mashed Potatoes Frozen Peas Lettuce Wedge With Roquefort Cheese Dressing Pineapple Sherbet • Cream of Pea Soup Baked Ham, Noodles Grilled Tomato Half Gelatin Fruit Salad on Shredded Lettuce Fresh Applesauce	**15** Pineapple Juice Bacon, Scrambled Eggs • Vegetable Noodle Soup Swedish Meat Balls Buttered Potato Buttered Summer Squash Chef's Salad Bowl Custard Pudding • Pepperpot Soup Macaroni and Cheese Buttered Spinach, Lemon Banana in Red Gelatin Graham Cracker Roll With Whipped Cream	**16** Fresh Plums Poached Egg on Toast • Vegetable Soup Chicken à la King, Rice Buttered Asparagus Tips Peach, Cottage Cheese Salad Baked Date Pudding With Date Sauce • Cream of Tomato Soup Salisbury Steak Baked Potato Glazed Carrots Tossed Salad Baked Apple With Whipped Cream	**17** Persian Melon Bacon, Cinnamon Toast • Scotch Broth Braised Short Ribs Steamed Potatoes Frozen Mixed Vegetables Celery Hearts Strawberry Shortcake With Whipped Cream • Cream of Corn Soup Leg of Lamb, Gravy Mashed Potatoes Frozen Peas Orange Slices With Prune Center Pineapple Bavarian Cream	**18** Grape Juice Bacon, Scrambled Eggs • Beef Barley Soup Country-Style Steak Mashed Potatoes Julienne Beets, Lemon Lettuce Wedge With French Dressing Cup Cake, Sauce • Beef Vegetable Soup Lamb Pot Pie Steamed Potato Peas, Carrots, Celery Tomato, Cottage Cheese Salad Fresh Applesauce
19 Fig Sauce Poached Egg on Toast • Vegetable Soup Lobster à la Newburg Escalloped Potatoes Tomatoes Tossed Green Salad Lemon Cake • Split Pea Soup Baked Salmon Custard Rice With Cheese Sauce Buttered Wax Beans Pineapple Salad With Stuffed Date Center Fresh Raspberries, Cream	**20** Fresh Grapes Bacon, Scrambled Eggs • Virginia Baked Ham Escalloped Potatoes Buttered Asparagus Carrot, Raisin Salad With Boiled Dressing Apple Crisp, Hard Sauce • Split Pea Soup Cubed Steak Baked Potato Mashed Hubbard Squash Gelatin Fruit Salad Watermelon Balls	**21** Fresh Apricots Poached Egg on Toast • Bouillon Turkey, Dressing Mashed Potatoes, Gravy Frozen Peas Cranberry Gelatin Salad Lemon Sherbet • Cream of Potato Soup Meat Balls With Gravy Steamed Rice Sliced Tomato Lettuce Wedge With French Dressing Sliced Peaches, Bananas	**22** Grapefruit Half Bacon, Muffins • Bouillon Roast Beef Browned Potato Buttered Green Beans Stuffed Celery Chocolate Pudding With Whipped Cream • Cream of Corn Soup Ham Timbales Homemade Noodles Harvard Beets Lettuce, Pear and Cottage Cheese Salad Fresh Boysenberries	**23** Fresh Strawberries Bacon, Soft Cooked Egg • Consommé Broiled Lamb Chop Parsliied Potato Escalloped Zucchini Squash Pears in Mint Gelatin Peach Shortcake • Oxtail Soup Cheese Fondue Baked Potato Braised Celery Green Candied Apple Ring Salad Orange Chiffon Cake	**24** Blended Fruit Juices Bacon, Cornmeal Muffins • Beef Bouillon Braised Beef Steak Mashed Potatoes, Gravy Buttered Spinach, Egg Frozen Fruit Salad Butterscotch Pudding With Whipped Cream • Cream of Pea Soup Green Stuffed Peppers With Rice, Meat Buttered Wax Beans Combination Salad Cherry Cobbler
25 Banana in Cream Poached Egg on Toast • Chicken Bouillon Meat Loaf Escalloped Potatoes Buttered Peas, Carrots Chef's Salad Bowl Prune Whip With Custard Sauce • Cream of Tomato Soup Stewed Chicken, Noodles Buttered Asparagus Candle Salad, Mayonnaise Frosted Cup Cakes	**26** Tangerine Juice Soft Cooked Egg • Split Pea Soup Salmon Surprise Buttered Rice Buttered Green Beans Gelatin Fruit Salad Bread Pudding With Lemon Sauce • Cream of Vegetable Soup Tuna Fish Salad Baked Potato Buttered Stewed Celery Sliced Tomato Salad Icebox Cookies Stewed Apricots	**27** Fresh Pears Bacon, Coffee Cake • Chicken Rice Soup Lamb Chop Creamed Potatoes Buttered Peas Red Gelatin With Cottage Cheese Pineapple Upside Down Cake, Whipped Cream • Clam Chowder Stuffed Beef Patties Steamed Rice Buttered Asparagus Carrots, Celery Fresh Grapes	**28** Persian Melon Bacon, Scrambled Eggs • Bouillon Fried Chicken Mashed Potatoes Buttered Beets, Lemon Lettuce Wedge With French Dressing Ice Cream • Cream of Vegetable Soup Cheese Soufflé Mixed Vegetables Sliced Tomato Fresh Fruit Salad Plate Baked Apples, Raisins	**29** Fresh Grapes Bacon, Cinnamon Rolls • Tomato Bouillon Breaded Veal Cutlets Mashed Potatoes, Gravy Baked Squash Lettuce Wedge With French Dressing Date Pudding • Vegetable Soup Chipped Beef and Noodles au Gratin Frozen Spinach, Lemon Waldorf Salad Fresh Sliced Peaches in Cream	**30** Frozen Orange Juice Poached Egg on Toast • Beef Barley Soup City Chicken Mashed Potatoes, Gravy Frozen Peas Tossed Salad With Roquefort Cheese Dressing Chocolate Pudding • Spun Egg Soup Chop Suey, Steamed Rice Julienne Carrots Lettuce, Pear and Cottage Cheese Salad Strawberries in Cream

Ready-to-eat or cooked cereals served on all breakfast menus.

DAY AFTER DAY rich flavorful coffee with TRI-SAVER COFFEE URNS

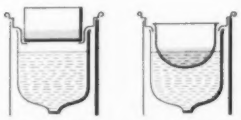
here's why:

No Filter Paper — No Urn Bags

The Tri-Saver patented permanent filter eliminates filter paper and urn bags, simplifies brewing, prevents spoiled batches due to torn filter paper or rancid urn bags.

Tri-Saver extracts more flavoring matter

Caffeol, the aromatic oil which gives coffee its distinctive flavor, is absorbed, to a considerable degree, by coffee bags and filter paper. Tri-Saver stainless steel filter does not absorb this valuable oil, gives a richer full-flavored brew.



No Cooking of Coffee Grounds

Tri-Saver filter prevents cooking of coffee grounds. Sagging urn bags often immerse coffee grounds in the finished brew — producing a bitter flavor. Tri-Saver, however, holds coffee grounds safely above the coffee level.

Send for TRI-SAVER BOOK

Tells the complete story of "Tri-Saver" coffee-making system. Describes single urns, batteries, twin, combination and institution urns. Capacities from 3 to 80 gallons. Available with thermostatic control and unbreakable stainless steel liners.

● Day in and day out, you serve consistently delicious coffee when you make it the Tri-Saver way. There is no guess-work in the simple coffee-making procedure. Tri-Saver's permanent stainless steel filter *eliminates urn bags and filter paper*... extracts maximum strength from your coffee. You get a rich, full-bodied brew that retains all essential flavoring matter. Tri-Saver stainless steel urns are easy to clean—providing further sanitary aids to fresh, sweet coffee goodness. For an investment that will pay rich dividends in terms of long service, low upkeep, easy operation and customer satisfaction —make your next coffee urn a "Tri-Saver."

This permanent stainless steel Tri-Saver filter eliminates urn bags and filter paper. A quick rinse prepares it for the next batch. Coffee grounds cannot clog the Tri-Saver filter.

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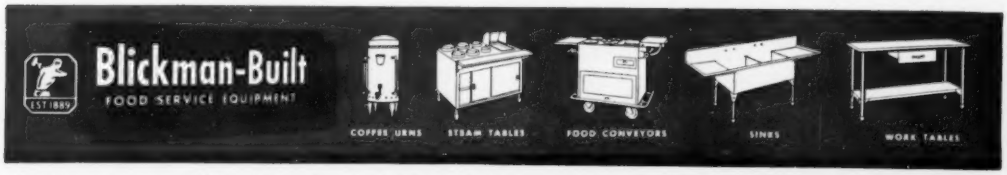


We welcome you to our exhibit at the American Hospital Association Convention, Convention Hall, Booth 329, Philadelphia, September 15-18.

RADIO PAGING goes into the doctor's pocket

CHARLES F. NEERGAARD
Neergaard, Agnew & Craig
New York City

IN COMPANY with everyone who has ever had much to do with hospitals, whether doctor, nurse or patient, I have long been aware of the inadequacies of existing methods of paging the medical staff.

As long ago as 1939 I was convinced that the only feasible method of calling a specific individual without disturbing others and without ever failing to make contact would be some short wave radio system. However, I am no radio expert and there was little I could do on my own to perfect such a system.

IT DID WHAT IT SHOULD DO

Actually, it was not until early in February of this year that we finally were able to test the first radio paging system that proved to do everything such a system should do. A 5 watt transmitter located on the tenth floor of a Cleveland hospital broadcast a weak but ultra-high frequency signal to a receiver small enough to fit in the breast pocket of a business suit and started a buzzer that told the carrier of the receiver that he was wanted. That signal was received everywhere in the building, penetrating even into the deep x-ray therapy room, which was completely lead-lined and had its door closed!

The story behind the new radio paging system is not a simple one to outline. No one event or invention made it possible.

I became interested in the problem early in 1939, when I had an extended stay in a hospital as a patient. I learned then how painful and infuriating audible paging can be to the patient and as soon as I was well I began a long campaign to promote the development of radio paging. In 1942 I read a paper before the annual meeting of the New York State Hospital Association in which I discussed doctors' paging systems, stating that in my opinion none of the existing systems was satisfactory. I visualized a wireless radio system which would sometime be developed and which would be the perfect answer to the problem. In the intervening 10 years I approached a score of manufacturers, electronic research laboratories, and engineers, all of whom said that the idea was practical and only needed someone to work it out, following intensive research, but none of whom did anything about it.

Finally in 1951 I was able to interest Harry Royal in the idea. He was a manufacturer of electronics equipment for hospitals and had on his staff a young engineer, Al Gross, who was best known for his war-time development of the compact walkie-talkie radio used by the O.S.S. in the underground in Europe. Gross had talked with me about it several years ago and said that the idea was practical and could be worked out. He started in at once in the Cleveland laboratory and began developing the essential elements of the paging system. Within six weeks of the time he started, or by the middle of February 1952, the first working prototype of the system had been tested and found practical.

Three basic elements are essential for any operating radio circuit, in addition to varying amounts of electric power. These are a transmitter, a receiver and "space" in the air. The last requirement is of enormous but not always recognized importance. In actuality, such space is rarer and harder to come by than fine diamonds, particularly for those people who do not have radio broadcasting licenses. In radio paging for hospitals, the license requirements could be an almost insuperable barrier, since operators' licenses usually cannot be obtained by anyone who is not the equal in knowledge to a full-fledged electronics engineer.

USES "CITIZEN'S BAND"

However, a certain remarkable and virtually unknown wartime development in American radio broadcasting known as the Citizen's Band makes possible just such broadcasting as is required by a radio paging system — nonlicensed broadcasting. The Citizen's Band, as it is popularly known among radio experts, is a special section of the ultra-high frequency radio spectrum, from 460 to 470 megacycles. In 1945 the Federal Communications Commission assigned this band to the free and unlicensed use of American people. No operator broadcasting on this band has to be licensed. The only control exercised by the F.C.C. is over the types of transmitters used; these must be licensed, or approved, by the commission. This means that since our new transmitter has been approved by the F.C.C. any telephone operator in a hospital can become a radio broad-

caster if she can work the simple controls, which are nothing more than rows of push buttons.

Now the Citizen's Band, which is not thus far used for voice broadcasting, is highly penetrating within its power range, because of its extremely short and rapid wave lengths. However, like any other radio system the broadcast call ordinarily could be heard by anyone with a receiver tuned to those wave lengths. In other words, it was quite unselective. This was death to selective calling, of course; for on these terms if one doctor was called every doctor whose receiver was on the same wave length would also get the signal.

It is here that Al Gross' inventiveness came into play. By an arrangement of special selective crystals, in both sending and receiving sets, it is possible for the transmitter to broadcast more than 800 noninterceptible signals to 800 different receivers. Each signal goes out on a complicated wave system which only one receiver can unscramble and receive; all the other receivers remain mute.

Obviously the average hospital will never need as many as 800 receivers, but the typical installation may have between 100 and 200. Fifty watts of power will give a four-mile range, more than ample for any hospital. The radio call system will not interfere with any other electronic device operating within or without the hospital and—even more important—these other devices, such as short wave therapy machines, x-ray machines, diathermy machines and the like, will not interfere with the paging signal, either when sent or being received. This has been established again and again by exhaustive tests in many types of hospitals.

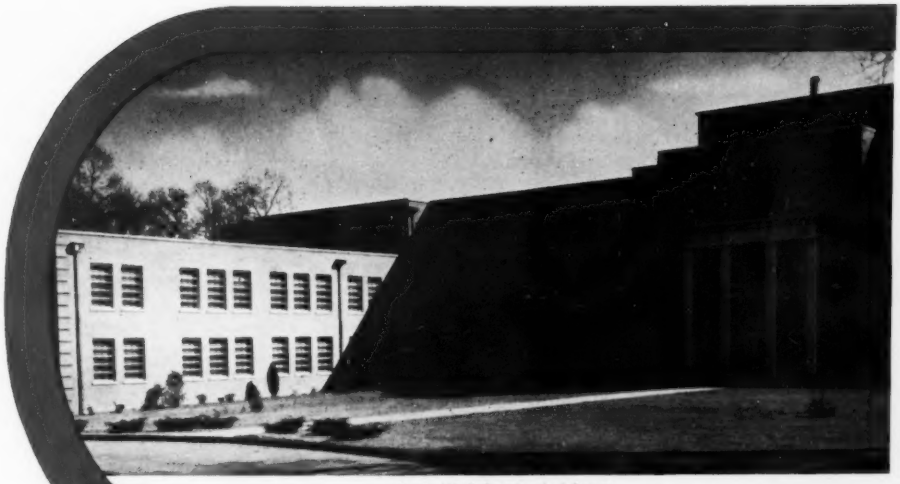
One of the reasons for the success of the new call system is the kind of signal the transmitter broadcasts and the receiver receives. It is less than five millionths of a second long. After that infinitesimal "pinggg!" the receiver itself takes over and performs the actual signaling. So short a broadcast signal cannot reach other receivers because of the high selectivity of the crystal tuning in both transmitter and receiver and will not interfere elsewhere in the radio spectrum because it is weak, power-wise, astonishingly brief and extremely concentrated. It does not "spread" to other parts of the radio band.

HOW IT WORKS

What, then, is the nature of the gadget the doctor himself will carry around with him in the hospital, which receives the broadcast and notifies him that he is wanted? It is a small plastic box about 2 inches longer than a package of cigarets. Complete with batteries and all the rest of the complex electronic equipment it contains, the little receiver weighs just 12 ounces, not enough to stretch the breast pocket where it can be carried.

The receiver is much like the receiving unit of a typical hearing aid. However, in addition to the necessary amplifying equipment and batteries that are found in the hearing aid, the paging receiver also contains miniature radio receiving equipment (much of it in the form of "printed" circuits), an aerial—the plastic case itself becomes the aerial—the special crystals that make each receiver so sensitive, and the tiny buzzer that calls the doctor's attention to the fact that he is wanted.

The buzz is a unique sound. Like a shrill mosquito, it cannot be ignored; but unlike the mosquito, it is very short in its audible range. The phy-



New 400 bed unit of Arkansas State Hospital at Benton, Ark.

Versatile, Easy to Clean

VULCAN
STERLING

Selected by ARKANSAS STATE HOSPITAL

Ease of cleaning and the flexibility of Vulcan cooking particularly pleased the management of this hospital, since most of the kitchen help are aged women who are inmates of the hospital.
Coupled with these desirable features, of course, is Vulcan's reputation for economy. For Vulcan owners the nation over report substantial savings in both food and fuel as a result of their Vulcan installations.

This kind of overall cooking efficiency is the reason why Vulcan•Hart sells more units of commercial cooking equipment than any other manufacturer.
If you are planning a new kitchen, or remodeling an old one, and be the job large or small, you'll find that there's a Vulcan to fit your particular need.
For complete information consult your Vulcan dealer or write direct to 18 E. 41st, New York 17, Dept. 14.

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sician cannot miss hearing it because it is so penetrating, but persons outside his immediate vicinity cannot hear it at all because of the signal's small volume.

The receiver, furthermore, has one other essential device within its crowded confines. That is a shut-off button. As soon as the doctor hears the buzz he can reach into his pocket and push the small button at the top of the receiver, thus turning off the signal and resetting the unit so that it can receive again.

In place of the conventional in-and-out register at the entrance of the hospital, there will be a rack with a series of pigeon holes. In the smaller hospitals each doctor will have his own numbered receiver which he takes out of the rack on his arrival. In the larger hospitals and medical centers where there are several entrances the doctor will pick up a receiver wherever he comes in and his number for the day will be telephoned to the switchboard. The rack is wired to a visual annunciator board in the telephone operator's room. When a doctor takes his receiver from its pigeon hole, an electrical contact is made by a release button, which indicates on the annunciator board that the receiver bearing that number is now being carried. This is obviously an efficient and nearly foolproof method of operating the system, as long as the doctor carries his receiver.

The system can be installed in any hospital with no wiring except the connection from the in-and-out rack, if used, to the switchboard and the cable connection between the transmitter and the antenna. The transmitter is generally located close to the telephone switchboard and the transmitting antenna is strategically placed within the building where it will provide the most complete coverage of the hospital and its immediate surroundings.

In the telephone operator's room, convenient to the switchboard, there is a small keyboard on which there are three rows of 10 numbered buttons. When these buttons are pushed in the correct sequence and the "transmit" button is depressed, the contact for broadcasting to a specific receiver is made and the signal goes out to that receiver and to no other. Small installations may have larger button boards with complete code numbers on each button; this should be feasible up to, say, 100 buttons for an equal number of receivers. The operator then would have to push only the one button bearing the number of the receiver being carried by the doctor who was wanted.

In any event, the push button method of making radio contact with the receivers completely eliminates the possibility of a "spreading" signal reaching more than one receiver. The only possibility of the wrong receiver getting a signal arises from the operator's error, and this possibility cannot be eliminated by any man-made invention yet known.

As the call system has no structural barriers and can penetrate any section of the hospital, use of the units by the maintenance staff will usher in a new era of improved emergency service. One of the medical centers is going to provide 30 receivers for its top maintenance men.

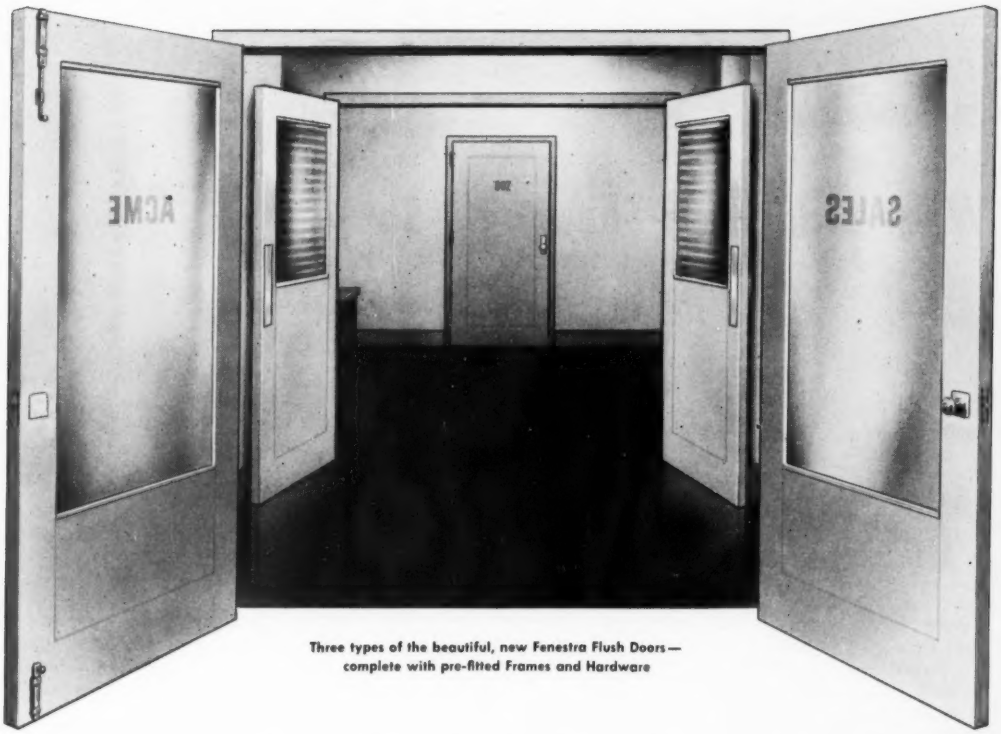
In the last few months the paging system has been demonstrated to a dozen or so leading hospitals and medical centers throughout the country, all of which have signified their interest in this development and many of which are now considering proposals for installation.

The paging system was demonstrated at the Pentagon on May 15 before a large group of officials representing the army, navy, air corps, V.A., Public Health Service and State Department. There were 32 present.

A 50 watt transmitter and aerial were set up and a prototype of the receiver was shown. This consists of a plastic case, metal plated, which serves as the antenna and houses the many miniature parts necessary for receiving the selective signal.

The meeting was held in a room on the fifth floor, south center, and the signal was picked up by the receiver in a room on the northwest corner of the second floor, which indicated that complete coverage of the immense structure was practical. A great deal of interest was shown in the demonstration and many significant questions were asked.

This call system in all likelihood would not have been developed as swiftly had it not been for the "needling" its developers received from hospital designers and architects and from administrators and hospital trustees to get the system perfected and into production as rapidly as possible, so that it could be included in the plans for new hospitals and made available to existing institutions.



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Conducted by Alta M. La Belle and Jane Barton

What Standards Should Be Set

by and for the housekeeping department

EMILY C. DEMING
Executive Housekeeper
Butterworth Hospital
Grand Rapids, Mich.

EVEN to define "standards" as the word applies to hospitals defies any dictionary that I have found, and I did actually trot down to the library and look in the fattest ones on the shelves. Yet, probably nowhere in the world do we need to be surer that we know exactly what standards we have, and how they are to be maintained, than in a hospital.

Before we establish what standards there are to be for other people and functions in the hospital, it seems to me we would do well to establish a standard for the executive housekeeper as the working head of a busy department, and it had better be a pretty stern standard covering personal appearance, an unbiased approach to personal and personnel problems, a receptively tolerant and cooperative attitude toward other department heads and their problems, and a detailed understanding of what we expect to offer our administrator in quality of service.

MUST TELL EMPLOYES

With budgetary limitations and administrative requirements as our twin guides, we must make an equitable departmental standard of service, bearing in mind exactly those things required of our particular department in our particular hospital. After we determine what standards are necessary for equipment and personnel and how best to allocate each for a working whole, we need to have a standard of expectancy for the work of each person in our department. It is important not only that we know what we expect and require of that person, but even more important, that the other person know what is required of him whether it is the assistant housekeeper, head houseman, pediatrics maid, elevator operator, messenger girl, washman or diaper folder.

The standard expected of each worker should be properly written down. It is very helpful in dealing with employes if you have the impersonal go-between of a written standard. If the written standard for the department being surveyed is 20 rooms per maid per day, each room to be mopped each second day, venetian blinds dusted twice weekly, bathrooms serviced four times per day, the individual who fails to meet this standard frequently has a far less defensive attitude in conference because the discussion can be centered impersonally on the written standard and how to meet it, rather than beginning with the personal failure of that individual.

Your standards must extend to every area that you service, and, if you would minimize friction with other departments, again you will have a written standard of exactly what service you are prepared to offer, how much dusting you can do and how often, how many times a week you can mop a given floor, how frequently the windows can be washed, inside and outside. For instance, it should be clearly understood whether the housekeeping maid or the laboratory deiner washes down the slab after an autopsy. Again standards enter. If housekeeping washes it down then the maid or houseman responsible for the job needs a standard procedure. Probably the pathologist will have indicated the cleaning agent he prefers to have used but the employe must have an exact procedure to follow.

In a few instances there may be only one way to accomplish an end result to meet a necessary standard. Usually, however, even the one and only procedure can be followed harmoniously if the housekeeper will confer with the head of the department requiring such service, presenting the method she wishes to follow, and asking pleasantly if this is acceptable. Nine times out of 10 even a fussy department head will be receptive if the matter is well presented and will tell you to use your own judgment. In case of controversy and a demand for some other technic or method, don't hop on your high horse. A wise compromise may save endless friction, and if the standard can be reached, that is all that matters unless it increases the work load unduly. Occasionally one has to take a firm "do or die" position, but let it be the last position and seldom resorted to.

MORE THAN ONE STANDARD

To particularize a given standard in this type of discussion is to invite disaster. Therefore, I shall invite only two: the first, by considering a clean floor. Now it is easy to shrug a clean floor off with the assumption that it either is or it isn't. Actually, it is not as simple as this. The same floor cleaned in the middle of a winter blizzard and on a sunny afternoon in June would require two standards. To achieve those two standards would require a far different working schedule, which means a different working standard.

But let's start at the beginning, and that beginning was before the building was built. If you are working with something that exists, that's it. How-

Paper presented at the Tri-State Hospital Assembly, May 1952.

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ever, during a building program you may well be invited to sit in with the architect, administration and building committee. If you are, you may effectively block a white marble lobby, you may be able to help guide the choice of floor for patient rooms, and so on.

If you are given a choice, remember that your choice must be dependent upon a number of factors. First come physical location of the hospital, the type of community in which it is located, the type of hospital, *i.e.* general, obstetrical, T.B., geriatric or orthopedic. On all of these factors hangs the choice of floors for entrance areas, public corridors, waiting rooms, patient rooms. On these factors, too, will depend your standard of cleanliness and the cleaning standard necessary to achieve it. In the Middle West you may clean your lobby in June twice a day, buff it once a week, and have a sparkling clean floor. During a blizzard day in December you may assign a houseman to do nothing but clean this one area, *ad infinitum, ad nauseam,* and still achieve nothing but a muddy floor, and yet by your midwinter standard it has to pass for clean.

MUST BE TAILORED TO FIT

Actually, all I have said means just one thing: Your standard must be tailored to your own hospital, your own location, your own particular patient load, the number of staff allocated to your department, and the quality of work you can achieve from that staff, dependent upon the efficacy of your training program and supervision. But, above all else, since you achieve no result except through people, your results are achieved by the desire you create in your staff to meet your own particular standard in your own hospital.

Second, we will consider a blanket. Much ado about nothing you think? Would you buy the same blanket for winter in Minnesota as for winter in the Imperial Valley of California? Again, begin with your own particular plant and individual needs. Consider next the blanket itself, the quality of the wool, whether it is domestic or foreign, reprocessed, sweepings, virgin or a combination of these. Rarely do you buy a 100 per cent wool blanket; therefore, you must decide in what proportion the wool shall be combined with other material and with what other material—wool and cotton, wool and rayon, wool, cotton and rayon, and so on. Do you want a shrink-resistant blanket?

Another factor that must be considered is whether you are to wash the blankets or they are to be sent out to be washed. If they are washed in your own plant, the type of equipment you have will affect your choice of blanket. Must your blanket be washed in a single speed machine or do you have a two-phase motor? How well does your washman follow instructions? What drying facilities do you have, an adequate draw type of dryer, or must you string them on poles when you go home at night?

The type of patient might, in large measure, control the choice of color. The maternity ward could well rate soft pink blankets, while an incontinent geriatric ward would much more appropriately have a heather blend or darker color. No simple matter, this, just to choose a blanket, and so far we haven't even mentioned price or pounds or size!

No matter what we buy, no matter what our procedure, there must be a carefully thought out standard for it. For many items there are excellent guides; the A.H.A. has provided us with some, incidentally, an excellent one on blankets. For many items there are government standards set by the Bureau of Standards. Appliances such as the electrical devices we use, floor waxes, and so on must meet the standards of the Underwriters Laboratories. For a hundred other items, your sole guide must be your own common sense, personal research, purchase from a reputable house, the how, where and why of the particular purpose of the item purchased, or the result to be achieved by the procedure under study.

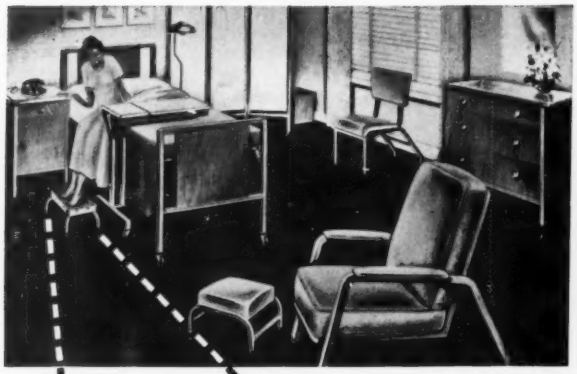
There should be a standard procedure for the cleaning of all isolation areas. It should be clearly understood by both nursing and housekeeping whether the housekeeping staff does the unit in toto, including all furnishings and mattresses, or whether it merely does the physical room, walls, windows and floors. Again, there should be a written procedure available to any person on duty in the department in any emergency that states exactly how a room shall be cleaned after gas bacillus, scarlet fever, T.B., meningitis and so on. This standard should include extremely detailed instruction for the protection of the maid or houseman who will carry out the procedure. You can never be sure of a good cleaning standard in this type of unit unless the worker concerned feels perfectly safe and relaxed in doing his job. He'll cut corners no matter how good your supervision if he is frightened and thinks he may be going to carry some serious disease home to his family.

Linen standards are probably, in spite of all the so-called yardsticks, one of the trickiest to establish. Certainly, they are one of the most important so far as our patient comfort and public relations are concerned, and I mean public relations not only as it affects the patient directly, but also as it affects the nursing staff, because unless your linen standard approximates what the nursing staff thinks the patients ought to have, no matter if the sheets are changed three times a day, they will still carry away the impression, gained from the nurses, that the linen supply is inadequate

ESTABLISH LINEN COMMITTEE

In establishing a linen standard or adjusting the existing standards, I think it extremely important to have a committee representing administration, purchasing, nursing and housekeeping. After it has been determined how much linen each patient on each type of service is to be allowed, how much service linen is to be allowed, *i.e.* staff uniforms and tray linens, a proper method of maintaining this standard of service must be worked out. Whether your standard is established on the basis of pounds per day or pieces per patient (which to me is a fairer patient standard because your service linen is then properly rated as service linen), it is necessary that you have enough linen to maintain this standard over week-ends, on holidays, during machinery breakdowns, staff illnesses, or other emergencies. The patient doesn't give a hang whether you've got hot or cold water in the laundry, but he cares very much whether he has a clean towel when he washes his face. And the housekeeper needs must be the guiding force in arriving at the original standard for linens needed to meet the service demands, and cushion the emergencies that are inevitable. It serves no standard well to say you need seven sheets per patient bed if you know nine is the fewest you can function with.

The standard of maintenance for house furnishings will vary with in-



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stitutions and probably vary within each institution depending on the type of service rendered by each individual unit. For instance, most of us will send a sheet with a minor repair or a small stain to our ward service but not to our private pavilion. We would send a private room lounge chair out to have the first scratch repaired; we might wait until the second or third if the chair were in ward service.

Our training standards are of paramount importance and extend far beyond the actual staff on our department pay roll. Lay and nursing staff, new classes of students, members of other departments can well profit by an insight into the problems of housekeeping, and the approach that gains readiest response is emphasizing our value as a basic service department to release whomever we are presenting the matter to for the direct function of his own particular department. This is no "tongue in cheek" matter: We should do just that if we meet minimum standards of good housekeeping, for we are just that—"basic service" for everyone else.

Because of individual educational limitations of our employes, their inability to take notes either during or after a "lecture," or inability to read with comprehension, it behooves us to set careful standards for teaching our own staff. Rattling off a clever lecture, no matter how well it covers the problem, teaches no one who sleeps through it! Seldom does it pay to teach more than one-half hour at a time. A simple "show and practice" method for a small group at a time, using as nearly as possible the exact situation your staff meets, gives far more in results. And beware of teaching more than one or two procedures at one time, or sure as sin you'll find Susie carefully using toilet bowl technic on the hall drinking fountain!

If you can devise a simple picture story of the procedure you have taught to be kept on file in each maid's or houseman's closet, fine! Your results will last longer. You may groan at the amount of teaching time this method presupposes, but if you are consistent, if you and your supervisors are persistent, you will find the time more than saved for you in lessened supervisory load, and better standards everywhere in the department. Incidentally, before we leave the teaching problem, be sure your supervisors all know what your standards are as well as you do: Give them special preliminary training so that they have the security of certainty in working with floor staff. Nothing breeds greater confidence than assurance in the teacher! Nothing begets better standards of work than good instruction and consistent supervision.

Standards are never ending, for once one has been achieved one's sights can be moved up a notch toward an even higher standard. The housekeeper and her department can make valuable contributions in the area of those standards best understood by patient and family, *i.e.* clean linen, clean bedrooms, clean and cheerful waiting and reception rooms. And we can make substantial contribution to all the other departments of the house by giving cheerful, efficient service that meets the highest possible standard.

After my administrator read this far, he invited me to say that no matter how good our standards of cleanliness are, it is our standards of dirtiness that people will see and comment on! The immaculate ward, the long, shining corridor, the gleaming tile in O.R., none of these rates a word of commendation, but Heaven help you if the top of one door frame needs dusting, if one of your dear staff members has put his heel on the wall by the drinking fountain, leaving a clear block print—for these gross sins you will be soundly and thoroughly chastized. You can deliver 50,000 pieces of linen weekly to your floor services and never a murmur reaches you, but the morning two extra scrub caps are needed in O.R. for the 8 o'clocks, the entire plant rocks on its very foundation. You are condemned as a walking menace to public life and safety.

With all my heart I hope your administrator is as aware of this inverse side of standards as mine is, for then your job will be as strenuous, pleasant and rewarding as mine is. Nothing is more work or more fun than good housekeeping and that is a synonym for good standards.

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(*Continued From Page 75*)

supported by the Church or not. For example, if people want to run a school for blue-eyed people they have a right to do so under our Constitution, but they then should pay the taxes that are inherent in the maintenance of such an institution. I don't think that public maintenance should be expected for institutions that draw the line on either race, color or religion. I hardly think it is just pure chance that a large number of Catholic people happen to be in one institution. I think that we have to be very frank and first say that there is prejudice in this, and then we have got to get it out. If we say that everything along these lines is satisfactory, we are going to wind up by accomplishing very little. I am sure there is a great deal of prejudice involved in the situation, and unless we get rid of it we will not be able to solve these problems.

NEED NOT BE DISCRIMINATORY

DR. MULLIN: I would like to comment on the picture as a factor in admission. If an admission committee has 1300 applications for 72 places available, it is extremely difficult to keep these applicants in mind. The picture is of help only in terms of identifying the applicant who may have been there for an interview. Needless to say, the picture can also be used for discrimination—there is no question about that. On the other hand, I think it is also fair to say that the picture may not be used for discrimination. I can speak for two schools where I know pictures are not used for discrimination.

MSGR. BARRETT: Speaking for Loyola University, I don't believe that during the last 20 years there has ever been a nonwhite applicant turned down for that reason alone. As a clergyman, Major Calloway, I can't help but point out that many other sectarian groups maintain institutions of higher learning at a great deal of sacrifice to the membership of their various denominations. Perhaps the Catholic Church may do that more so than others, but it is because we consider education and religion as very important things. Loyola University medical school runs an annual deficit of approximately $200,000 and that is very largely, but not exclusively, made up by contributions of Catholic people. The same people who are paying for education in private medical schools are paying taxes to help to support the state medical schools and other divisions of state universities. They are doing it out of religious conviction, and at double the cost.

DR. ANDERSON: If a school is going to discriminate, it is going to have ample chances in which to get whatever information it wants to make a discriminatory selection of its students. I think it is foolish to put so much emphasis on a picture.

MR. CUNNINGHAM: You have heard a variety of views by the panel, all the way from Dr. Anderson, who sees evidence of discrimination in favor of the Negro applicant, to Major Calloway, who sees evidence of discrimination against him.

We will now move along to opportunities in nursing education, and I am going to ask Mrs. Buccieri, representing the Illinois Nurses' Association, to give us a report of current educational opportunities for nonwhite nursing students.

MRS. BUCCIERI: The American Nurses' Association has formed an intergroup relations committee. It has stated that the professional qualifications of the nurse should be the criteria by which she should be chosen. Its policy is to eliminate discrimination in job opportunities, salary and working conditions, and, last, to include minority groups in membership.

The National Association for Colored Graduate Nurses has been disbanded, but there are still a few local chapters in existence. The retention of some of these local units prohibits integration within the framework of the nurses' association.

I think that professional nursing groups could set up special committees on intergroup relations and use them as a means for the Negro nurse to bring her particular problem to the nursing profession. We want to promote nursing service to the public, and that would be one way of doing it. Today approximately 10 or 12 schools, out of some 30 in our immediate area, are admitting applicants on a nondiscriminatory basis.

MR. CUNNINGHAM: Can you give us any clue as to the reason the other 20 are not, and what may be done to accomplish the job there?

MRS. BUCCIERI: Of the 10 which have open policies, many are tax supported. There has been only one Protestant hospital school which has opened its doors to nonwhite students.

MSGR. BARRETT: I don't like to speak for the membership of the Chicago Hospital Council, and I therefore would rather confine my observations to the Catholic hospital schools of nursing, in which, over the years, I believe there has been notable improvement in the admission of qualified nonwhite applicants. Offhand, I can think of at least five Catholic schools of nursing in the area that admit qualified nonwhite students and have been doing so for several years. I deplore that when I started in the health field in Chicago nearly 20 years ago, I don't think there was one school in our group that admitted nonwhite students. If they did, they were isolated cases, cases in which exceptions were made.

POLICIES GETTING BROADER

If I may speak for other than the Catholic schools, I think there has been a broadening of the policy, at least in some of the schools. I believe those hospitals which have not established an open policy of admission are considering doing so. With the number of schools of nursing in the Chicago area that now do have an open admission policy, I think any qualified nonwhite applicant will find a place and I only hope that the time isn't too far away when admission to any school of nursing in the Chicago area would be available to a qualified nonwhite applicant.

I might point out the fact that in the class admitted at Provident Hospital School of Nursing last September, they had only about 50 per cent of the number they were able to take care of. If there are any number of Negro and other nonwhite applicants available, they must have gone to other schools. I point that out for the purpose of indicating that all nonwhite qualified applicants for nursing in the Chicago area certainly have the opportunity of getting into qualified schools.

MR. CUNNINGHAM: I think we should move along to this difficult problem of hospital staff appointments. A report rendered by Dr.

McLean indicates that there are now 37 Negro physicians serving on the staffs of 12 hospitals in the Chicago area. That sounds like substantial progress over the previous period, but Dr. Raines has indicated that opportunities for the Negro physician in private practice were rather restricted. Dr. Raines, in your opinion, do the 37 physicians on the 12 hospital staffs represent real progress toward solution of the problem as you outlined it?

DR. RAINES: I feel that it represents a trend. It represents good will, but I think that there has not been as much real progress as the figures would indicate. The thing that really determines whether or not the Negro physician has been accepted on the staff is whether or not he is able to get his own patients into the hospital. As far as I know, I would say that the Negro physicians here still have to take 99 per cent of their patients to Provident Hospital.

MAJOR CALLOWAY: Can you name a hospital where a Negro doctor can take one of his patients—a private hospital?

DR. RAINES: I can name a few. One of them is Michael Reese Hospital. They have about four men on their staff and I think they can take their own patients there.

MAJOR CALLOWAY: Do any of those men at Michael Reese Hospital have full hospital privileges?

DR. RAINES: I think one of them has courtesy privileges. I understand that one of them actually has got his patients into the hospital. The other three men are only on the clinic staff.

HOW MANY HAVE VOTE?

MAJOR CALLOWAY: I was going to bring out the point that a lot of these appointments referred to here are appointments that are not on the participating or voting staff of these hospitals. I would like to know how many of these 37 are on hospital staffs and actually have a vote on hospital staffs?

MR. CUNNINGHAM: Those figures referred to are all the appointments, and some of them would be classified as limited appointments?

DR. RAINES: Yes.

MR. CUNNINGHAM: It seems that there is some substantial progress represented here, but I think we must agree with Dr. Calloway that Negro physicians in private practice have been extremely restricted in their opportunities. What kind of recommendations may be made with the idea of looking forward to the removal of those restrictions?

DR. RAINES: This problem is primarily a medical one. When the medical men in the community are made aware of their responsibilities in this matter, we might expect some improvement. There is another factor that has to be taken into consideration, and that is the fact that the governing board of a hospital is made up of lay persons. Those lay persons are supposedly public-spirited citizens of the community who have high ideals and devote themselves to public health service. I believe they can have a great influence at the policy making level of the institutions which they serve. It has been my experience that a medical staff is very willing to cooperate with the governing board. When hospital boards are made aware of this problem, we will be making some progress. The policies of the hospitals depend upon the men. You finally get down to that factor.

MR. CUNNINGHAM: I think we should take up the question of direct discriminatory selection in the admission of patients to hospitals, apart from the problem of hospital staff appointments, and discriminatory placement of patients within the hospital.

MSGR. BARRETT: As of today, a great deal of progress has been made. There are some hospitals in the Chicago area which do not admit Negro patients—other than in emergency cases. I am sure, however, that they are very much in the minority. Most hospitals, particularly those of which I have some knowledge, do admit Negro patients.

In my position as director of Catholic hospitals here in Chicago I find myself in an advisory capacity to the hospitals with which I work, but I deplore the fact that it is difficult, next to impossible, for a qualified nonwhite physician to get a staff appointment on the staff of the hospitals in the Chicago area. I have a host of friends among the medical profession, but I lay the responsibility for the situation more to the staffs of hospitals than to their governing boards. In a limited number of cases I have made a personal effort to engineer the appointment of a colored physician to the staff of a Catholic hospital, and the opposition has been from the staff. We might as well lay the cards on the table.

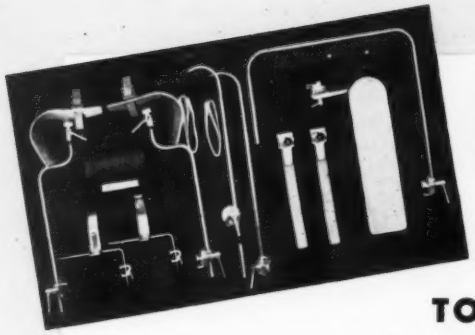
MR. CUNNINGHAM: I think we are all certain that if all men had as good intentions as you have, we would not be here today discussing this problem. Dr. Raines said that the Packinghouse Workers Union had recommended the prohibition of the expenditure of public funds in any medical institution which discriminates against Negroes in any manner whatsoever, such as in the selection and treatment of patients. Dr. Calloway, assuming that is a desirable objective, how would you determine whether or not an institution is so discriminating?

"TOO GOOD" FOR THE JOB

MAJOR CALLOWAY: I have no idea how I would determine that. I would like to tell you of something that occurred here in the city and you can judge for yourself. About two years ago, we went to one of the large hospitals in the city that had the "carriage trade," and we approached it as to the appointment of a Negro doctor on its staff. Officials told us that during the entire existence of this hospital, some 50 years or more, they had never had the application of a competent Negro. This we took at face value. We asked them about the requirements and they told us all the requirements which were necessary. We then procured an individual who met all of the requirements and he applied. The result was rather amazing, and points out the fact that we are dealing with discrimination and we have to face the issue. They stated that this man was so well qualified, and the position they had to offer him was so far below his qualifications, that they didn't think he should be appointed to the staff!

I am not so sure that all the blame belongs on the staff. Most of these hospitals are actually run by nonmedical people, and the policies which are fixed for the institution are fixed by these people rather than by the staff; matters of policy are fixed by the board of directors and nobody else.

Since 1776, the U.S. Army has steadfastly maintained a segregated policy. A few years ago, since World War II, it suddenly decided that Negro doctors were doctors also, and did an about-face. Two things resulted: The first was that it was an open admission that it was wrong before; second, it couldn't find enough people who met its qualifications. Today, however, the Negro physician in the medical corps is sent into all parts of the world, and in most cases he is not designated by



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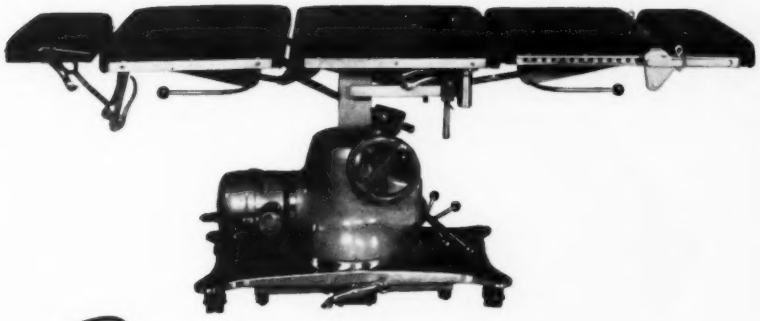

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race. There is no picture that accompanies him, and the commander who gets him can like it or not. This situation has worked out very well. There have been some objections on the part of some commanders, because they thought that all sorts of things would happen. However, nothing has happened thus far, and we have been accepted on an equal level with other doctors.

In connection with putting colored doctors on the staffs of civilian hospitals, I would like to point to what we did in the army. Once it was decided that Negro doctors were going to fit into the medical picture, it was done right down the line. At the present time I am assistant chief of medicine at the Percy Jones Army Hospital. It is the first time in the history of the army that a Negro has been in such a position in a general hospital in the United States Army. There have been no difficulties with subordinates, no difficulties with nurses, and no difficulties with patients.

MR. CUNNINGHAM: Before we leave the subject of hospitals, I think it should be pointed out that hospitals, as a matter of economic necessity, must find some financial resources to support the care of patients, particularly those who are brought in during emergencies. They must, therefore, sometimes decline to accept patients when no medical emergency is involved. When that patient is a Negro there is an assumption of discrimination, which may or may not be true. This is a very difficult thing to determine. Possibly the financial responsibility may be a screen for discrimination, but certainly there are instances in which the hospital is justified in taking this step as a matter of financial necessity.

DR. MCLEAN: With respect to hospital staff appointments I might say that very little progress of a concrete nature has happened. It is true that 37 individuals in Chicago have been accepted by their colleagues for appointments to staff positions. It is also true that in very few instances do these appointments give the privilege of taking patients to the hospital. This is only in part a discrimination against the Negro. It is actually discrimination by the "ins" against the "outs." We have to remember that in each one of the hospitals the staffs have grown up from the bottom. These men have all spent years on the staff and acquired seniority, and they do not easily yield their seniority rights to anybody else, whether white or black. For that reason, more than any other, I believe that the attempt to crash the hospital staff is going to be very difficult and it is going to take a long time. During this time I think that progress will be made from the bottom. We have made almost a complete break-through at the intern level; we are making very rapid and considerable progress on the resident level and when these residents have completed their training they will be appointed to junior staff positions and will then compete with the other doctors of similar age and training for advancement on those staffs.

As that process goes forward I see the time approaching, neither next week nor next year, but I do see the time approaching, when the Negro will be on hospital staffs in some fair proportion. Of all of the situations we have discussed, the situation with respect to the Negro physician and particularly with respect to senior Negro physicians on hospital staffs, is the worst and also is the most difficult to deal with.

NEGROES IN MEDICINE:

Southern Hospitals

(*Continued From Page 79*)

In the same state another large institution reported: "We have separate buildings for Negroes and whites. The one for Negroes is perhaps one of the finest in the whole world. We wanted to use Negro doctors but couldn't get them. Did not have the courtesy of a reply from the only Negro physician I wrote."

While, conceivably, there may be no Negro doctors practicing in some of the areas reporting, the evidence points strongly to a deliberate exclusive policy on the part of the majority of hospitals or their affiliated medical societies:

"Hospital by-laws state that an M.D. has to be a member of the county medical society to become a member of the staff, and Negroes are not eligible for membership . . . therefore, cannot be accepted on hospital staff."

"There is no rule against admission of Negro physicians, however they must be members of the medical society. This has caused them to not yet be able to apply for membership."

What may we expect in the future? One administrator in the deep South struck a hopeful note when he commented: "We are noticing a continual and progressive trend toward giving equal recognition to Negro and white people . . . and as administrator of the hospital I want it to continue so."

However, out of these findings it would be hard to establish a spontaneous trend toward integration on the part of Southern hospital administrators and the boards they represent. Rightly or wrongly, the initiating impulse toward a more democratic use of these facilities seemingly must come from outside. One might predict a sequence of court actions similar to those which have opened the doors of many erstwhile "lily-white" educational institutions—and be confident of the same felicitous acceptance of the result by the Southern public. Nor is the day for such a reckoning far off. An increasing shortage of hospital facilities is making a bad situation unbearable. More and more Southerners are coming to realize that the only humane and democratic way to meet the issue is to share what there is according to need and not on the basis of racial fiat.

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READING GUIDE

(*Continued From Page 82*)

reader to find answers or further references on day-by-day operational problems.

Readers should familiarize themselves with the services available at the Library of the American Hospital Association, Asa S. Bacon Memorial, 18 East Division Street, Chicago. A selected catalog of books plus a listing by subjects covering articles, clippings, pamphlets and reprints available for loan may be found in "The Magic Key to Hospital Literature" distributed by this association. However, it is recommended that the listings contained therein be regarded as a supplement and not as a substitute for the accompanying basic reading list.

A comprehensive catalog by subject matter and authors is also contained in the "Cumulative Guide to Hospital Literature, 1945-1949" and in the semi-annual "Index of Current Hospital Literature" published by the American Hospital Association.

As it is not expected that every hospital or agency will own copies of every publication on this list, interested readers should get in touch with local public libraries, county medical societies, the library of the American Hospital Association, near-by universities, and other resources for assistance in locating this material.

The references are classified with the intent of orienting the reader in the following:

1. The broad general problems of planning and administration, and the background of medical care and public health as a preface to better patient care.

2. The problems of hospitals and hospital administration in terms of over-all objectives and basic philosophy.

3. The specific problems and goals of the various departments and areas within the hospital.

A. PREFACE TO BETTER PATIENT CARE

Adler, Mortimer: ***How to Read a Book.*** **New York, Simon & Schuster, 1940.**

Regardless of one's educational background, a study of the philosophy and recommendations presented in this now almost classic treatise will assist him in acquiring efficient reading habits. The ability to translate words into knowledge efficiently and easily is a precious asset for any executive.

Binger, Carl, M.D.: ***The Doctor's Job.*** **New York, W. W. Norton & Co., 1945.**

A readable introduction to modern medicine as a profession and as a science, accenting its more humane and psychiatric aspects. Valuable background reading for the layman entering the hospital field.

Boas, Ernest P., M.D.: ***The Unseen Plague — Chronic Disease.*** **New York, J. J. Augustin, 1940.**

A nontechnical authoritative presentation of the social import of chronic disease. Today with the ever-increasing awareness and growth of this problem, a knowledge and understanding of its significance is basic in the development and education of future hospital administrators.

Boomer, L.: ***Hotel Management.*** **New York, Harper & Bros., 1946.**

Considered a classic not only in the field of hotel management but also in the field of management as an art. As there are many similarities in the operation of hotels and hospitals, particularly from the standpoint of cost accounting, purchasing and maintenance, this book is a valuable source of information for the hospital administrator.

Emerson, Haven, M.D., Ed.: ***Administrative Medicine.*** **New York, Thomas Nelson & Sons, 1951.**

A compendium of articles on all aspects of organized care of the sick and public health. Parts I and II contain much of interest for hospital people.

Goldman, Franz, and Leavell, Hugh R., Ed.: ***Medical Care for Americans. The Annals of the American Academy of Political and Social Science,*** **Vol. 273, (January) 1951.**

A valuable collection of articles by leading authorities on problems of medical care.

Hutchins, R. M.: "The Task of the Administrator Is Ordering the Means to the End." ***The Modern Hospital,*** **71:51 (November) 1948.**

A thought-provoking account of a philosophy of administration by an outstanding educator-administrator. A "must" for anyone seriously interested in the education of administrators or in the art and science of administration.

Mott, Frederick D., and Roemer, Milton J.: ***Rural Health and Medical Care.*** **New York, McGraw-Hill Book Co., Inc., 1948.**

A valuable source of facts, figures and recommendations on health conditions, medical resources, and organized efforts for health improvement in rural areas.

Mustard, Harry S.: ***An Introduction to Public Health.*** **New York, The Macmillan Co., 1945.**

An orientation to the field of public health for the nonspecialist.

National Health Assembly: ***America's Health—A Report to the Nation.*** **New York, Harper & Bros., 1949.**

Findings and recommendations on vital problems of national health.

Schell, E. H.: ***Technique of Administration: Administrative Proficiency in Business.*** **New York, McGraw-Hill Book Co., 1951.**

Case studies of administrative and personnel problems are presented and various approaches to their solution are posed by the author. A stimulating introduction to the problems of administration.

Simon, H. A., Smithburg, D. W., and Thompson, V. A.: ***Public Administration.*** **New York, A. A. Knopf, 1950.**

An introduction stressing the fact that an administrative organization is a group of people and should be studied and administered with this in mind.

Stern, Bernhard J.: ***American Medical Practice in the Perspectives of a Century.*** **New York, The Commonwealth Fund, 1945.**

A broad description and history of medical practice in the United States, highlighting the reciprocal interplay among social, technological and economic forces and medicine. Recommended for an understanding of the origins of present-day problems of medical care.

Stern, Bernhard J.: ***Medical Services by Government — Local, State and Federal.*** **New York, The Commonwealth Fund, 1946.**

A summary of the complex and expanding field of government medical services, tracing their historical developments and outlining the relative responsibilities of local, state and federal governments.

Strauss, Bert and Frances: ***New Ways to Better Meetings.*** **New York, The Viking Press, 1951.**

A nonacademic presentation of practical methods of making meetings, committees or conferences produce more effectively.

B. HOSPITALS AND HOSPITAL ADMINISTRATION

American Hospital Association — Administrators Guide Issue of ***Hospitals,*** **June 1951. Part II.**

A valuable summary of hospital statistics and managerial data. Also contains a guide to the hospitals of the United States, its territories, and Canada. This issue is published each June and is distributed as part of the regular subscription to the journal.

"Elements of Hospital Operation" (Reprinted from ***Hospitals,*** **July 1950). Prepared by the Division of Medical and Hospital Resources, Public Health Service, Federal Security Agency, Washington, D.C.**

An annotated checklist of typical problems and situations encountered in the administration of hospitals.

Bachmeyer and Hartman, Ed.: ***Hospital Trends and Developments.*** **New York, The Commonwealth Fund, 1948.**

A compendium of selected articles appearing in the literature of hospital and allied fields since 1940.

Corwin, E. H. L.: ***The American Hospital.*** **New York, The Commonwealth Fund, 1946.**

An authoritative review of the development and present status of the American hospital. Current problems of plant, administration and finance are discussed in terms of what has been done, is being done, and remains to be done.

Faxon, Nathaniel W., M.D., Ed.: ***The Hospital in Contemporary Life.*** **Cambridge, Harvard University Press, 1949.**

A series of lectures designed to tell the layman about the past history, present operation, and future possibilities of hospitals.

Goldwater, S. S., M.D.: *On Hospitals.* New York, The Macmillan Co., 1947.

A compilation of the writings of an eminent hospital administrator. An important contribution which emphasizes the need for developing a warm humanistic philosophy and applying sound basic knowledge in the field of hospital administration and management. Nowhere is the patient ever overlooked or forgotten. A work which should be reread and subjectively applied at various periods of the administrator's lifetime.

Hayt, Emanuel and Lillian R., and Groeschel, August H., M.D.: *Law of Hospital, Physician and Patient.* New York, Hospital Textbook Co., 1952.

A revised edition of a basic reference which treats all aspects of hospital activity and their legal implications.

MacEachern, Malcolm T. M.D.: *Hospital Organization and Management.* Chicago, The Physicians Record Co., 1946.

A comprehensive reference in the field of hospital management.

McGibony, J. R., M.D.: *Principles of Hospital Administration.* New York, G. P. Putnam's Sons, 1952.

A noteworthy, recent contribution to the field of hospital administration covering every aspect of hospital operations and community relationships.

Southmayd and Smith: *Small Community Hospitals.* New York, The Commonwealth Fund, 1944.

A useful treatise on the problems of the small hospital emphasizing community aspects, building design, staffing problems, and the economics and administration of hospitals of about 50 beds in size or smaller.

C. ADMINISTRATIVE AND CLINICAL ACTIVITIES WITHIN THE HOSPITAL

1. Accounting and Statistics

Block, L., Spanier, D. H., and Berberich, J. V.: *Adequate Financial Support for Hospital Maintenance and Operation.* Public Health Service Publication No. 76, Division of Medical and Hospital Resources, Public Health Service, Federal Security Agency, Washington, D.C.

Gilman, Stephan: *What the Figures Mean.* New York, Ronald Press, 1945.

A brief but valuable introduction in relatively nontechnical language to the methods of analyzing and using simple statistics in management.

Roswell, Charles G.: *Accounting, Statistics and Business Office Procedures for Hospitals.* New York, The United Hospital Fund, 1946.

A sound presentation of good accounting and business procedures written so as to be useful to both the hospital administrator and the hospital accountant.

2. Building Maintenance and Operation

Development of Fire Emergency Programs. American Hospital Association, Chicago, 1951.

Hospital Fire Safety. National Fire Protection Association, Boston, 1951.

March, C. A.: *Building Operation and Maintenance.* New York, McGraw-Hill Book Co., 1950.

Basic information on building maintenance presented in easy to read, nontechnical language. A valuable addition to the library of the hospital administrator or engineer.

Recommended Safe Practice for Hospital Operating Rooms. National Fire Protection Association, Boston, 1951.

3. Community and Public Relations

Hawley, Paul R., M.D.: "Medicine as a Social Instrument: The Hospital and the Community." *New England Journal of Medicine.* 244:256 (Feb. 15) 1951.

Hyatt, Dave: *Introduction to Public Relations.* Extension Bulletin No. 5. September 1950. Cornell University, Ithaca, N.Y.

A practical guide designed to give a quick over-all view of the field of public relations, a glimpse of some of the methods used by business concerns and other organizations, and some hints on how to use the tools of public relations.

Mills, Alden P.: *Hospital Public Relations.* Chicago, The Physicians Record Co., 1939.

A standard reference on hospital public relations.

4. Dietetics

"Food Service." *Hospitals,* June 1951, Part II, Management Guides, pp. 11-30.

Harrington, May: "Administration of Dietary Department." *Journal of the American Dietetic Association,* 16:621. (August-September) 1940.

Taylor, W. R., Kaufman, Miriam, and Jones, Edith A.: "Cooperative Planning of Dietary Services for 50, 100 and 200 Bed General Hospitals." *Journal of the American Dietetic Association,* 27:937 (November) 1951. (Same article appeared in November 1951 issue of *Hospitals* magazine.)

West, B. B., and Wood, L.: "Food Service in Institutions." Chapter 12, *Organization of Food Service,* 2d Ed., 1945. New York. John Wiley and Son, Inc.

Ordinance and Code Regulating Eating and Drinking Establishments: 1943, Recommendations of the Public Health Service. P.H.S. Publication No. 37. Washington, D.C. Government Printing Office, 1950.

Recommended standards for sanitary control of food and food preparation.

5. Governing Board

"The Board's Control of Hospital Medical Care." Reprinted from *Trustee,* the Journal for Hospital Governing Boards. American Hospital Association, Chicago, 1950.

Trusteeship—A Symposium on the Governing Board and the Administrator. Addresses of the 15th Annual Meeting, American College of Hospital Administrators, Chicago.

6. The Hospital Medical Staff

"Essentials of an Approved Internship" (Rev. to December 1948; originally published in the *J.A.M.A.,* 72:1757, June 14, 1919). Prepared by the Council on Medical Education and Hospitals of the American Medical Association, Chicago.

"Essentials of Approved Residencies and Fellowships" (Rev. to December 1948. Originally published in the *J.A.M.A.,* 90:922, March 24, 1928).

Descriptions of current standards of medical education in hospitals. These pamphlets can be obtained from the American Medical Association, Chicago.

Medical Diagnostic Services for Small Communities. W. K. Kellogg Foundation, Battle Creek, Mich.

A nontechnical discussion of some of the steps which can be taken by small communities in providing modern consultative and diagnostic services.

7. Hospital Planning and Design

Butler, Charles, and Erdman, Addison: *Hospital Planning,* New York, F. W. Dodge Corporation, 1946.

An authoritative treatment of the planning and design of all types of hospitals.

Rosenfield, Isadore: *Hospitals — Integrated Design.* New York, Reinhold Publishing Corp., 1946.

A comprehensive review of hospital planning and design by a leading hospital architect.

"Design and Construction of General Hospitals." A Definitive Study of the Physical Aspects of the Hospital Plant in Relation to Its Function. Reprint from *The Modern Hospital.*

"Elements of the General Hospital." Reprinted from *Hospitals,* April 1952.

"Plans of General Hospitals for the Coordinated Hospital System." Reprinted from *Hospitals,* January 1948.

"Hospital Equipment and Supply Lists." Reprinted from *The Hospital Purchasing File.* 29th (1952) edition.

The foregoing "package" of reprints of articles prepared by the Division of Hospital Facilities, Public Health Service, Federal Security Agency, is a comprehensive guide to the functional planning of the modern hospital. All are available without charge from the P.H.S. office, Washington 25, D.C., and in regional offices located in New York, Boston, Cleveland, Chicago, Atlanta, Kansas City, Dallas, Denver and San Francisco.

8. Hospital Pharmacy

Cook, E. F., and Martin, E. W.: *Remington's Practice of Pharmacy.* 10th Ed. Easton, Pa. Mack Publishing Co., 1951.

Chapter 101 on "The Pharmacist in Public Health" and Chapter 104 on "The Hospital Pharmacy" contain excellent summaries of these subjects.

9. Housekeeping and Laundry

La Belle, Alta, and Barton, Jane P.: *Administrative Housekeeping.* New York, G. P. Putnam's Sons, 1951.

Hospital Laundry—Manual of Operation. American Hospital Association, Chicago, 1949.

A basic reference on the operation of the hospital laundry. Contains practical information on linens, washroom practices, textile damage, stain removal, and equipment and machinery.

10. Medical Records

MacEachern, Malcolm T., Dr.: *Medical Records in the Hospital.* Chicago, The Physicians' Record Co., 1937.

A standard reference.

11. Medical Social Service

Some Aspects of Social Casework in a Medical Setting: A Study in the Field of Medical Social Work. Prepared by Harriett M. Bartlett for the Committee on Functions, American Association of Medical Social Workers. Chicago, George Banta Publishing Co., 1945.

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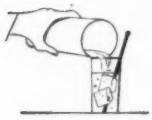
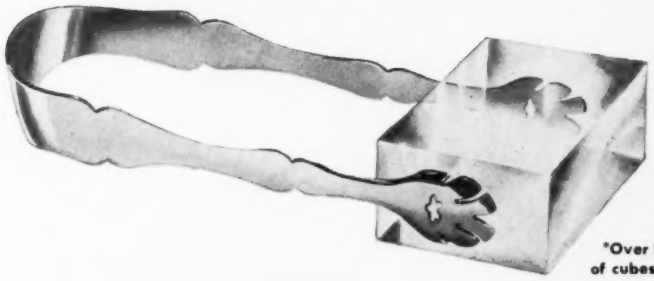


BARS

HOTELS

HOSPITALS

RESTAURANTS



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A detailed treatment of fundamental principles and concepts related to the practice of social casework in hospitals.

12. Nursing and Nursing Education

Hospital Nursing Service Manual. Prepared by a Committee of the A.H.A. and N.L.N.E. New York, National League of Nursing Education, 1950.

A valuable synopsis of the principles of good nursing service in a hospital.

Nursing for the Future. A Report Prepared for the National Nursing Council by Esther Lucile Brown, Ph.D. New York, Russell Sage Foundation, 1948.

An important contribution on the future of nursing education in terms of the nursing and health needs of society.

Practical Nurses in Nursing Services. Prepared by the Joint Committee on Practical Nurses and Auxiliary Workers in Nursing Services of the A.N.A., N.L.E. and other associations. New York, 1951.

An important pamphlet dealing with the services of practical nurses, their development, preparation, and rôle in patient care.

Proposals for the Improvement of Nursing Education and Service. Interdepartmental Health Council of New York State. Albany, N.Y., December 1950.

A proposal for an experimental amalgamation of some nursing and practical nursing educational programs.

13. Outpatient Department

Bigley, Loretta I.: *Community Clinics*—The Hospital Outpatient Department and Nonhospital Clinics. Philadelphia, J. B. Lippincott Co., 1947.

A practical guide to establishing and operating various types of clinics in the hospital, listing space, personnel and equipment needs.

14. Personnel Administration

"Departmental Oganization of the Hospital." Reprinted from *Hospitals*, August 1951.

A preliminary description of hospital departmental organization. The authors fully recognize the fact that no two hospitals will have exactly the same internal structure or the same number of departments and also that all departments must operate as integral, well functioning parts of the total hospital activity. A more elaborate treatment is given in the final compilation published by the Government Printing Office (1952) entitled "Job Descriptions and Organizational Analysis for Hospital and Related Health Services."

Kalsem, P. J.: *Practical Supervision.* New York, McGraw-Hill Book Co., 1945.

A readable presentation of the supervisor's rôle in the organization's daily operations. Points out what is expected of the supervisor by the workers and by top management.

Scott, W. D., and Others: *Personnel Management: Principles, Practices and Point of View.* New York, McGraw-Hill Book Co., 1949.

A standard text on personnel management in the field of industrial relations. However, the principles, practices and points of view are fundamental and can be easily adapted to the hospital field.

Staffing the General Hospital—25 to 100 Beds. Prepared by Margaret K. Schafer, Division of Medical and Hospital Resources, Public Health Service. Reprinted as Publication No. G25-49 by the American Hospital Association, Chicago, 1951.

A tabulation of staffing patterns from data collected in selected hospitals of fewer than 100 beds in different parts of the United States.

15. Physical Medicine and Rehabilitation

Essentials of a Hospital Department—Physical Therapy. Chicago, American Hospital Association, May 1949.

Medical Addenda: Related Essays in Medicine in the Changing Order. New York, The Commonwealth Fund, 1947.

Essay on "Rehabilitation and Convalescence" (pp. 103-126) by Howard A. Rusk, M.D., is an illuminating summary.

16. Purchasing and Matériel Management

Brady, George S.: *Material Handbook: An Encyclopedia for Purchasing Agents, Engineers, Executives, and Foremen.* New York, McGraw-Hill Co., Inc. 1951.

A vast store of constantly useful information on selecting and specifying materials.

Lacey, Walter N.: *Purchasing for Hospitals.* Chicago, The Physicians' Record Co., 1947.

A standard reference manual.

Melnitsky, Benjamin: *Management of Industrial Inventory.* New York, Conover-Mast Publishing Co., Inc., 1951.

A valuable recent contribution which stresses inventory management as the science of scheduling, preplanned turnover, positive control, and calculated risk.

YOU CAN BE **SURE**... IF IT'S **Westinghouse**

New addition to Southern Baptist Hospital, New Orleans, La. Hospital-proven Westinghouse Elevators take on another job where dependability is a "must."

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Medical specialists are consulted when expert advice is wanted. Their ability to solve specific problems is supported by years of study and experience.

And it's much the same chain of action that is leading hospital after hospital after hospital to Westinghouse for expert advice on vertical transportation. For years, Westinghouse Hospital Elevator specialists have been gaining experience in the installation of elevators designed for hospital use.

This means smooth-riding, accurate-landing, smooth-stopping rides for patients, staff and visitors alike. And all this with built-in economy of operation and maximum service efficiency.

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Says Dr. Frank Tripp, Southern Baptist Superintendent, "We are 100% satisfied with our Westinghouse Elevators. We like the equipment and the service they give is excellent."

If you have a part in planning vertical transportation, consult Westinghouse hospital elevator specialists. You owe it to your investment. Westinghouse Electric Corp., Elevator Division, Dept. K, Jersey City, N. J.

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J-98640

Hospital Elevators

MEDICAL RECORDS

(*Continued From Page 89*)

which he is referred. She then gives him the card and directs him to the other clinic, sending his chart on ahead to the receiving clinic by messenger. If he is to return for further treatment, the clinic receptionist gives him an appointment.

Patients' charts and visit cards are picked up from clinics regularly during the day and returned to the record room. There, the visit cards are given to the census clerk who tabulates from the cards, counting the visits to the outpatient clinic and to each specialty clinic according to first visits and revisits. The census clerk enters a penciled check mark on the date line of each card to indicate that these visits have been tabulated. Thus, visits recorded on a card returned later always can be added to the figures for the correct day, and none will be overlooked. Both the visit cards and charts are returned to the files.

At the close of the day, each clinic receptionist sends to the record room two copies of her appointment list for the following day. The evening file clerk makes out a charge-out card for each record requested on the appointment list, assembles the charge-out cards in numerical order, and withdraws the charts and visit cards from file, leaving the charge-out card in the file for each chart removed. The records for each clinic are stacked together ready for delivery to the various clinics the next morning.

Visit cards are placed in alphabetic order and the following morning are given to the central receptionist, together with a copy of each appointment list. When the patient returns to keep his appointment, his visit card is waiting for him at the reception desk, and his chart is already in the clinic.

It has been our experience that the smooth operation of this record system depends upon three essentials:

First is the use of an appointment system. If a majority of patients use the clinic services by scheduled appointment, charts can be made available in advance and a substantial load is removed from the transportation system, which otherwise may bog down and produce a long delay in rendering care to the patient.

Second, the assignment of a file clerk for late afternoon and early evening hours permits daily filing of all records used during the day and the withdrawal of records needed for the following day. This work can best be done when no other use is being made of the files and when the absence of pressure permits greater accuracy of filing.

Third, the use of a single card, issued from a central source, to serve the dual purpose of authorizing treatment and collecting statistics has several values. The presence on the card of a clear mark, indicating the clinic to which the patient is going is helpful to him if the patient happens to forget his directions or becomes otherwise confused. Any employe can redirect him by referring to the mark on his visit card. No tabulations of visits need to be kept in individual clinics or at the admitting or reception desks, and no daily logs need be maintained. This system of obtaining statistics of clinic activities has proved to be most useful in obtaining current accurate data with

(*Continued on Page 152*)

"Might as well heat these rooms with old-fashioned stoves!"

WHAT in the world is this hospital board member talking about? Listen: *"Without Honeywell Individual Room Temperature Control, our new hospital will actually be out-dated before we open the doors. And now that we know this modern system will only cost between ½ and 1% of our total expenditure, I say we will be making a serious mistake if we don't install it now!"*

Is this an overstatement? Not as much as you might think—here's why!

Today, in many hospitals, it is already routine medical practice to give each patient the exact room temperature he needs to speed his convalescence. This can be done only if every room has its own thermostat. No other method can compensate for the varying effects of wind, sun, open windows and variations of internal load in each room.

Since that is true, it's just smart business to install individual room temperature controls *when your hospital is being built.* Doing it later, as a modernization project, is sure to cost substantially more money.

For complete facts and figures on Honeywell controls for your hospital, call your local Honeywell office—there are 91 of them located in key cities throughout the nation. Or for literature, write Honeywell, Dept. MH-8-176, 351 E. Ohio St., Chicago 11, Ill.

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Only thermostat specially designed for hospitals!

No other thermostat offers hospitals all these features:

- ***"Nite-Glowing dials"*** permit inspection without disturbing patients.
- ***Magnified numerals*** make readings easy to see.
- ***New Speed-Set control*** knob is camouflaged against tampering.
- ***Air-Operated;*** requires no electrical connections.
- ***Lint-Seal*** insures trouble-free and dependable operation.

BUYING DEPARTMENTAL EQUIPMENT?

Thirty-six leading manufacturers of laboratory equipment, sterilizers and stills, and equipment for physical and occupational therapy departments, radiology departments, and pharmacies have placed detailed catalog information in the copy of Hospital Purchasing File (29th Edition) now on your desk.

Whether your problem is a new department, additional or replacement equipment, reach first for Hospital Puchasing File. Encourage your laboratory and X-ray technicians, your pharmacists and other department heads to save their time and yours by looking first in HPF. Since 1919 (when this reference work was established as Hospital Yearbook) thousands of hospital administrators have found it a timesaving shortcut to product information; thousands of administrators have learned to rely on this big reference volume as a first source of buying data for the equipment and supplies used in every hospital department. See Sections GC, GD, GE, GF, and GG.

THESE MANUFACTURERS CAN HELP YOU. You will find their product information in Sections GC, GD, GE, GF and GG of the 29th edition of Hospital Purchasing File:

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Cambridge Instrument Company, Incorporated
Edin Company, Incorporated
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Electro-Medical Laboratory, Incorporated
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Leitz, Incorporated, E.
Sanborn Company

SECTION GD

Aetna Scientific Company
American Sterilizer Company
Barnstead Still and Sterilizer Company
Castle Company, Wilmot
Diack Controls (Smith-Underwood)
Prometheus Electric Corporation

SECTION GE

Birtcher Corporation
Burdick Corporation
Electric Hotpack Company, Incorporated
Hanovia Chemical and Manufacturing Company
Ille Electric Corporation
Medart Products, Incorporated, Fred

SECTION GF

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Fairchild Camera and Instrument Corporation
General Electric Company, X-Ray Department
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SECTION GG

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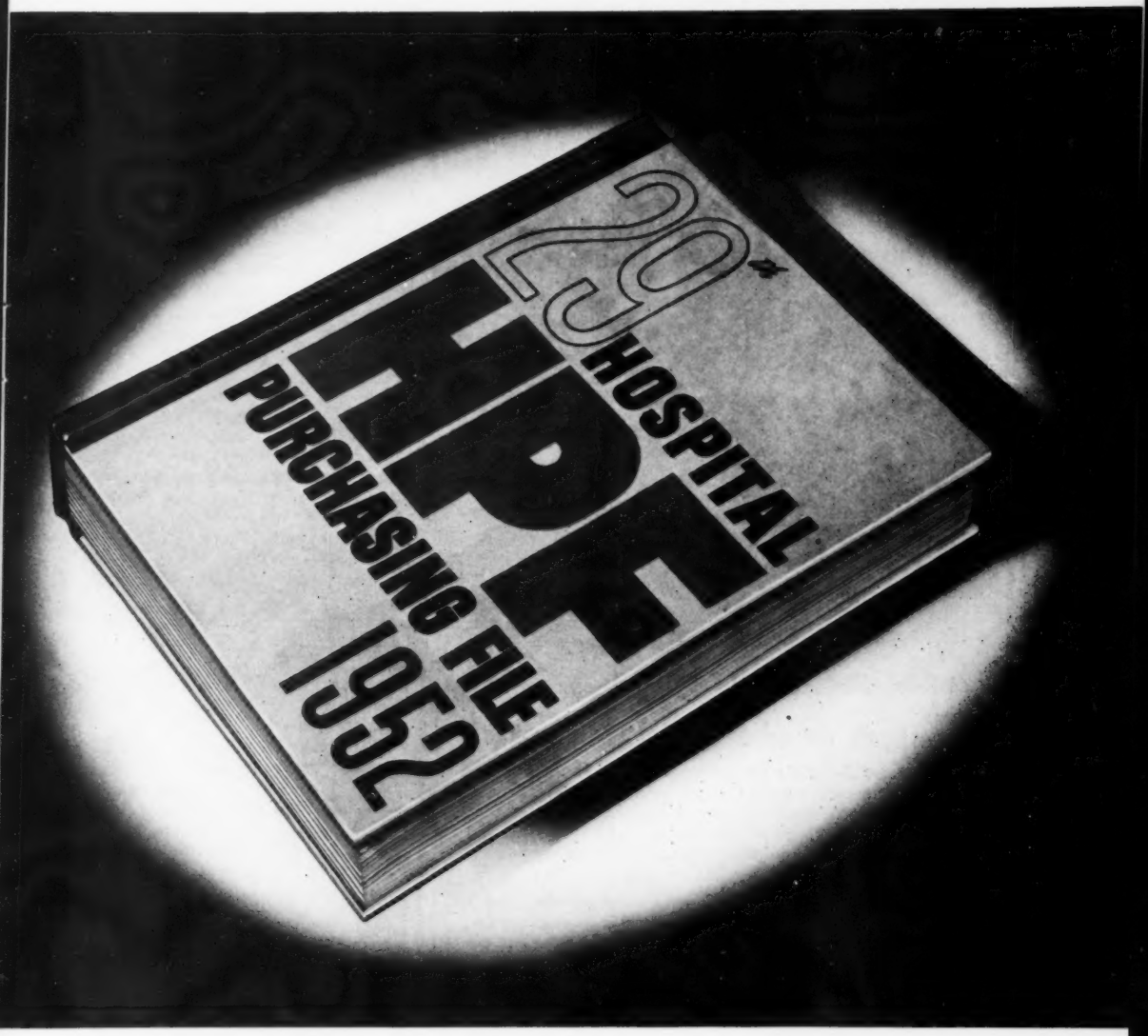

ESTABLISHED AS THE HOSPITAL YEAR BOOK IN 1919 BY THE MODERN HOSPITAL PUBLISHING CO. INC.

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a minimum of time and expense. The daily tabulation requires the time of one clerk for approximately 30 to 45 minutes, and the monthly summary another 30 minutes.

With 380 patients visiting the outpatient clinic daily, this record system has been successfully operated with the following employes:

Medical record librarian supervisor	1
Central reception	1
Admission of patients	2
Record room filing and tabulating	3
Abstracting of clinical records and central stenographic service	4
Transportation of records	1
Relief clerks to cover vacation and sick leave absences	2
	14

One of the clerks listed previously under record room filing spends about one-third of her time admitting patients during the busier clinic hours. In addition to these full-time employes, one employe works part time, four hours a day, as evening file clerk.

There also are 12 receptionists and secretaries who are assigned full time to serve the 15 specialty clinics and departments.

After the new record system had been successfully launched, attention was directed toward developing methods of further improving the quality and usefulness of records. Established diagnoses were recorded on the face sheet of the chart. A medical record committee was appointed, composed of the medical officer in charge, the chiefs of service, and the medical record librarian, to establish policies and to review a sample group of records at each regular meeting. This review covers the quality of medical care as well as the adequacy of the record.

Indexing of diagnoses is limited to selected diagnostic categories because, in our experience, case studies based solely on outpatient treatment are usually limited to specific, predetermined diagnostic groups, and routine indexing does not, therefore, appear to be justified. The medical record committee selects the diagnoses which are to be indexed.

Since the introduction of the new medical record system more than three years ago, minor procedural changes have been made, but the basic system has been found to meet our needs.

THE PREFERRED HOSPITAL PLUMBING

Surgeons Scrub-up Sinks from the new Crane line. Depth, width, height of spout and distance from back wall are planned for fast, easy, comfortable scrubbing of the whole arm. Made of Crane Duraclay to resist thermal shock, acid and abrasion.

"We use 35,000 gallons of hot water a day in this 335-bed hospital"

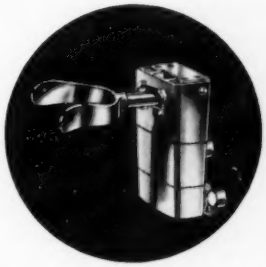
When hot water is such a major item, it pays to use it efficiently

The Chief Engineer of a leading midwest hospital of 335 beds told us they use 104 gallons of hot water per bed per day out of a total water consumption of 95,000 gallons per day, 35,000 gallons are charged with the additional expense of heating. Water is a major hospital expense item, hot or cold, any way you look at it.

That's why it's essential to use water efficiently, without waste. That's why Crane and hospital experts teamed together to design a complete new line of specialized hospital plumbing.

Besides saving water, these new fixtures can save work and precious minutes for your nurses, too.

See your new Crane hospital catalog for complete information. If you don't yet have your catalog, ask the man who calls on you from your Crane Branch or Wholesaler, or ask your local Plumbing Contractor. He will help you select the right fixtures for your particular requirements.



Knee Control of the water flow is an obvious advantage in a scrub-up sink. This Crane valve incorporates the Dialese type unit for easy maintenance. Valve closes with the water pressure instead of against it, for easy operation. Smooth control is assured, with no sudden temperature changes.

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NEWS DIGEST

American Nurses' Association Approves Reorganization Plan . . . Charge Medical Schools With Bias . . . New Hampshire Elects Officers . . . A.H.A. Meeting to Feature Informal Sessions . . . Settle 28 Effingham Law Suits

Nurses' Biennial Convention Approves Streamlining of Organization Structure

ATLANTIC CITY, N.J. — Reorganization of the nursing profession into two instead of several national organizations was completed here last month at the 17th biennial nursing convention, where plans for expansion of the American Nurses' Association and consolidation of other groups into the National League for Nursing were approved by official bodies of the several former organizations involved. The reorganization program followed several years of study and discussion of nursing organization problems.

Ruth Sleeper, director of the school of nursing at Massachusetts General Hospital, Boston, was named president of the new National League for Nursing, successor organization to the National League for Nursing Education, the National Organization for Public Health Nursing, and the Association of Collegiate Schools of Nursing. The new league represents some 25,000 nurses and lay members engaged in nursing education and service.

STUDY PRACTICAL NURSE GROUP

Tentative approval of a proposal to include practical nurses as members of the league was given by the convention, which authorized appointment of a committee to work with the National Association of Practical Nursing Education toward the development of an integrated program.

Mrs. Elizabeth K. Porter of the Frances Payne Bolton School of Nursing, Western Reserve University, Cleveland, was reelected president of the American Nurses' Association, which will henceforth be concerned with the organizational problems of professional nurses. Under new A.N.A. by-laws, sections for public health nurses, educational administrators and teachers, and other special groups were added.

In its final business session, the convention established the 40 hour week as a desirable standard, without reduction in existing salaries. The convention also approved demands for two consecutive days off and time and a half for overtime for graduate nurses on hospital duty. A resolution approved by the association said the 40 hour work week was a "valid, feasible and effective method of meeting current problems of staffing, recruitment and turnover" — notwithstanding the fact, pointed out in discussion, that only one-third of the nation's hospitals are now on a 40 hour week for graduate nursing personnel.

Other resolutions approved by the A.N.A. affirmed the graduate nurse's right as an individual citizen to make her own decisions regarding prepayment health and medical care plans "without fear or favor," and proposed pilot studies and survey programs aimed at improving the educational and employment status of Negroes and other minority group members in the nursing profession.

In addition to Miss Sleeper and Mrs. Porter, other officers elected by the two organizations were: National League for Nursing: first vice president, Frances Thielbar of the division of nursing education, University of Chicago; second vice president, Mae O. Spiegel, Chicago; third vice president, Dorothy Wilson, executive director of the New Haven Visiting Nurse Service, New Haven, Conn.; secretary and general director, Anna Fillmore, New York, and treasurer, L. Meredith Oaxson, Bronxville, N.Y.

American Nurses' Association: first vice president, Lillian Patterson, Seattle; second vice president, Mabel Montgomery, Richmond, Va.; secretary, Agnes Ohlson, Hartford, Conn., and treasurer, Annabelle Peterson, Washington, D.C.

Medical Schools Charged With Bias

NEW YORK. — Medical schools in New York State are discriminating against Jewish candidates for admission in violation of the state's Fair Educational Practices Law, the American Jewish Congress and the New York State Committee on Equality in Education charged here last month.

The two groups made public the results of a survey indicating that Jewish winners of the state's medical scholarships were denied admission to state medical schools in a ratio of two to one, compared to non-Jewish applicants.

The report said Cornell Medical College and the New York Medical College, particularly, appeared to discriminate against Jewish applicants. Cornell had accepted only one of 17 applications from Jewish candidates, it was asserted, while New York Medical College had accepted one of 13 Jewish candidates.

These and other medical schools had denied that discrimination was practiced, the report indicated. The schools argued that geographical screening of candidates resulted in elimination of some applicants from the city who happened to be Jewish, it was reported.

Long Island University Medical School was credited with the highest acceptance rate of applicants from the Jewish group, having accepted 27 of 29 Jewish candidates, the report said.

Oregon Elects President

Glenn Howell

PORTLAND, ORE.—Glenn Howell was elected to the presidency of the Oregon Association of Hospitals at the spring meeting of the association held here. Mr. Howell is administrator of Hood River Hospital, Hood River, Ore. Prior to entering hospital administration six years ago, he was for 12 years in the merchandising field and for seven years in the field of management in radio broadcasting.

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. . . Straight From The New Harvest Of World-Famous "Aristocrat" Tomatoes!

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Heinz fine new "crop" of tomato products is on its way—to help restaurant owners everywhere perk up fall and winter menus!

There's a complete line of harvest-fresh tomato products from which to choose—Chili Sauce, Ketchup, Tomato Soup, Tomato Paste, Tomatoes and Tomato Juice. Naturally, each is the outstanding tomato product in its class—for each is made by Heinz, a famous name in foods since 1869.

Your Friendly Heinz Man is authorized to take your order right now and fill it the minute these great new Heinz products are available! Order in advance and assure yourself an adequate supply of the finest tomato products you can serve!

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NEWS...

Hopkins Graduates 14 From Administration Course; Announces Appointments

BALTIMORE.—The recipients of master's degrees in hospital administration from the 1952 class have been announced by Johns Hopkins Hospital here.

They are: Dr. William Schaffrath, Edward Hammerbacher, Harry O. Humbert, Lt. Col. Robert S. Anderson, Dr. Alfredo Zepeda, Dr. Lee Janis, Morton N. Chalef, Dr. John Fauber, Col. James T. McGibony, Edward Ackerman, Lt. Col. Anthony Zolenas, Dr. Harry Nevel, and Dr. G. Kaelen.

Dr. Leroy E. Bates is a candidate for the doctor of public health degree.

Upon completion of the course, the members received the following appointments:

Dr. Janis is the new director of Menorah Hospital, Kansas City, Mo.; Dr. Schaffrath has been appointed assistant director at Menorah; Colonel McGibony has been assigned to command the Fort Belvoir Hospital in Virginia; Colonel Anderson is now assigned to Walter Reed Hospital, Washington, D.C.; Colonel Zolenas has been assigned to the Surgeon General's Office, Washington, D.C.; Dr. Fauber has resumed his post as assistant chief of dental services, central office, Veterans Administration, Washington, D.C.; Dr. Nevel has resumed his position with the Florida state health department as county medical officer; Dr. Zepeda is conducting research work at the Virginia state health department and in September he will return to El Salvador to supervise construction of four new units; Mr. Ackerman is now administrative resident at Mary Imogene Bassett Hospital, Cooperstown, N.Y., and Mr. Chalef is serving his residency at Johns Hopkins.

Select U.M.W. Hospital Sites

WASHINGTON, D.C.—The Memorial Hospital Associations of Kentucky, West Virginia, and Virginia have selected sites for 10 community hospitals. They will be constructed in the next three years with funds loaned by the United Mine Workers' Welfare and Retirement Fund to the associations for the fund's beneficiaries.

The sites chosen will be at or near: Harlan, Hazard, Middlesboro, Pikeville, Wheelwright, and Whitesburg, Ky.; Beckley, Logan, and Williamson, W.Va., and Wise, Va.

New Hampshire Elects Officers for Coming Year

WOLFEBORO, N.H.—Harold S. Fuller, administrator of Monadnock Community Hospital at Peterboro, N.H., was elected president of the New Hampshire Hospital Association at the association's annual meeting here June 12 and 13.

New Hampshire officers (l. to r.): Russell S. Spaulding, Harold S. Fuller, president; Dorothea Rice, and Robert D. Southwick.

Other officers elected for the coming year are: vice president, Dorothea Rice, superintendent of Elliot Community Hospital, Keene; treasurer, Robert D. Southwick, administrator of Concord Hospital, Concord, and secretary, Russell S. Spaulding, executive director of the New Hampshire-Vermont Hospitalization Service, Concord.

Goals Exceeded in Hospital Fund Drives

NEW YORK CITY.—Several hospital fund raising campaigns in which quotas were exceeded—by as much as 100 per cent in one case—were reported here last month. In five separate hospital campaigns, it was reported, an aggregate of $3,350,000 was sought and a total of $4,585,000 was actually subscribed.

The campaigns reported were conducted in Easton, Md., Allentown, Pa., Lowell, Mass., Woonsocket, R.I., and Battle Creek, Mich. Objectives ranged from $400,000 to more than $1,000,000 for financing new construction projects. The campaigns were directed by Will, Folsom and Smith of New York.

In another report released by the John Price Jones Company here, philanthropic gifts to health projects in 10 major cities totaled more than $36,000,000 in the first six months of 1952, compared to $24,700,000 for the same period last year.

A.H.A. 1952 Convention to Feature Informal Sessions

CHICAGO. — Informal round table discussions and meetings in which members of the audience will get into the act will feature the 54th annual convention of the American Hospital Association at Philadelphia, September 15 to 18, according to an announcement released at A.H.A. headquarters here last month. Topics to be featured in general sessions include reports of national commissions on hospital finance, hospital accreditation, and human relations, personnel problems, leadership training, and hospital trusteeship.

Section meetings are scheduled on plant operation, purchasing, nursing and other departmental functions.

The fifth annual conference of women's hospital auxiliaries, to be held concurrently with the convention, has scheduled workshop sessions on auxiliary programs, understanding the hospital and telling the hospital story. One meeting of the conference will be held jointly with hospital administrators attending the convention, it was announced.

Hospital Council Urges Changes in New York Setup

NEW YORK.—A revision of the "city systems and policies of control which now hinder efficient operation by the New York Department of Hospitals of its institutions for the care of the sick" was urged recently by the Hospital Council of Greater New York.

Home rule would let the department and its institutions "take definitive action in matters affecting patient care," and obviate present "antiquated and cumbersome" policies imposed by the city which cause delay, excessive expense and inefficiency, the council said.

Revision of these policies is the first of 15 recommendations made in the report, which the council undertook at the request of the Board of Hospitals. It climaxes a five-month investigation of Kings County Hospital.

The second recommendation dealt with the reduction of overcrowding. The most effective step, the report said, would be to transfer many of the chronic sick to other institutions or to home care. Thereafter, it asserted, the hospital should hold occupancy down to 95 per cent of normal bed capacity. Kings County Hospital had 105 per cent occupancy in 1951.

NOW A Different Dessert and Salad FOR DIABETICS EVERY DAY!

D-ZERTA HAS THE SEAL OF ACCEPTANCE OF THE COUNCIL ON FOODS AND NUTRITION OF THE AMERICAN MEDICAL ASSOCIATION

YOU KNOW how difficult it is to add variety to the menus of your patients on diabetic and reducing diets. That is why D-Zerta—the delicious saccharin-sweetened fruit-flavored gelatin—is such a wonderful discovery. For with D-Zerta, patients on low-calorie and low-carbohydrate diets can choose from more than 30 different desserts and salads. Your patients are provided recipes for all these dishes without charge.

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NEWS...

High School Seniors Serve as Nursing Aides in N.Y. Work-Study Plan

NEW YORK.—Under the Cooperative Education Program, worked out by the board of education and nine hospitals here to relieve the nursing shortage, 150 girl seniors in five high schools have been paired in work-study teams and alternate as nursing aides in the hospitals.

Under this rotation system, each student spends two weeks working at a hospital while her partner is at school. Throughout the school year the girls alternate every two weeks, so the hospital job is always covered. The girls receive the prevailing wage for nursing aides and are assigned, under professional supervision, to medical duties in line with their training and experience.

Nearly one-half the girls working in these teams have indicated that they will continue their education to become professional nurses.

The participating hospitals include: New York, Beth Israel, Mount Sinai, St. Luke's, Bronx, Lebanon, St. John's Episcopal, Brooklyn Jewish, and Prospect Heights.

Speaker Stresses Importance of Medical Clinic Practice

WICHITA, KAN.—"It is becoming increasingly difficult now for one man to handle all aspects of medicine for the convenience of the patient and the good of medical practice," Dr. Franklin D. Murphy, chancellor of the University of Kansas, told participants of the first regional institute for medical clinic managers held here recently.

"Clinic practice is one of the most important steps taken in medicine in the past 50 years. . . . The clinic will take on more and more significance in the future because a trend toward clinic practice will be encouraged by the complexity of medical knowledge," stated Dr. Murphy, former head of the Kansas State Medical Center, Kansas City, Kan. The institute was sponsored by the National Association of Clinic Managers and the southern section of the national group.

"If the patient becomes only a number or one of the mere mass of persons going down an assembly line, the all-important personal relationship between physician and patient is lost," Dr. Murphy warned. "We must increase efficiency of clinic practice, yet insist that personal relationship be permanently fostered and emphasized."

Minnesota Announces Residency Appointments

MINNEAPOLIS. — The University of Minnesota announces the following administrative residency appointments for students who completed the academic requirements in June 1952 and who will qualify for degrees in hospital administration in 1953:

Stanley N. Allen, Swedish Hospital, Minneapolis; Ivan D. Anderson, Stormont-Vail Hospitals, Topeka, Kan.; Marshall G. Ause, Mary Hitchcock Memorial Hospital, Hanover, N.H.; Sister Ingeborg E. Blomberg, Norwegian Lutheran Deaconesses' Home and Hospital, Brooklyn, N.Y.; R. Bruce Butters, Vancouver General Hospital, Vancouver, B.C.; Walter V. Coburn, Lowell General Hospital, Lowell, Mass.; Donald M. Cook, Memorial Hospital, South Bend, Ind.; John P. Davis, Johns Hopkins Hospital, Baltimore; Dr. Clovis W. Francisconi, University of Michigan Hospitals, Ann Arbor; Gunnar D. Frederiksen, Mount Sinai Hospital, Minneapolis; Henry G. Hemmerde, Asbury Methodist Hospital, Minneapolis; Gaston Herd, Norton Memorial Infirmary, Louisville, Ky.; Loren N. Hesla, Hillcrest Memorial Hospital, Tulsa, Okla.; Howard R. Jones Jr., Good Samaritan Hospital, Portland, Ore.; Roger G. Larson, Northwestern Hospital, Minneapolis; George B. Little Jr., Baylor Hospital, Dallas, Tex.; Arthur E. Miller, Tucson Medical Center, Tucson, Ariz.; David L. Odell, San Jose Hospital, San Jose, Calif.; Charles A. Okey, Ohio State University Medical Center, Columbus; Julio V. Olavarria, Lincoln General Hospital, Lincoln, Neb.; William W. Peters, Highland Hospital, Rochester, N.Y.; Tomic T. Romson, University of Minnesota Hospitals, Minneapolis; John Setsma Jr., Blodgett Memorial Hospital, Grand Rapids, Mich.; Donald S. Smith II, Minneapolis General Hospital, Minneapolis; John F. Stockwell, Rhode Island Hospital, Providence; James P. Streitz, St. Luke's Hospital, Duluth, Minn.; William N. Wallace, Charles T. Miller Hospital, St. Paul; John O. Yale, Syracuse Memorial Hospital, Syracuse, N.Y.; P. David Youngdahl, St. Barnabas Hospital, Minneapolis, and Glenn M. Reno.

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POWDERED CAROB FLOUR

The acute diarrheal disturbances seen so frequently in adults, infants and children during the warm months are promptly controlled by Arobon.

Made of specially prepared carob flour, Arobon produces its excellent results because of its high natural content of pectin and lignin. These substances are demulcent and soothing and they adsorb offending bacteria and toxins.

Controlled clinical studies [1, 2, 3] have shown that Arobon leads to thickening of the stools in 24 hours and to formed stools in 48 hours in most patients.

Indicated in all types of diarrhea, not only in infants and children, but also in adults, Arobon is palatable and readily accepted. It may be used as the sole medication in non-specific diarrheas. In the more severe dysenteries, it is a valuable adjuvant. Arobon is easily prepared for adults and children by simply mixing it with milk, and for infants by mixing it with skim milk or water and boiling for ½ minute.

1. Smith, A. E., and Fischer, C. C.: The Use of Carob Flour in the Treatment of Diarrhea in Infants and Children, J. Pediat. *35*:422 (Oct.) 1949.
2. Kaliski, S. R., and Mitchell, D. D.: Treatment of Diarrhea with Carob Flour, Texas State J. Med. *46*:675 (Sept.) 1950.
3. Plowright, T. R.: The Use of Carob Flour (Arobon) in a Controlled Series of Infant Diarrhea, J. Pediat. *39*:16 (July) 1951.

THE NESTLÉ COMPANY, INC., 2 William Street, White Plains, New York

NEWS...

Hospital Loses Tax Exemption

(*Continued From Page 66*)

the operation is one deliberately designed to produce income in excess of all operating costs," the decision stated. "The fact that plaintiff has succeeded in producing net earnings is not accidental or allocable to a fortuitous error in judgment in determining the charges made for its services. On the contrary, plaintiff functioned on a sound financial basis in a manner akin to any modern commercial enterprise intent upon producing a profit from its operations. It is argued that the above-indicated construction of the welfare exemption, denying exemption because of the adoption of sound financial practices, will make it difficult, if not impossible, for modern hospitals to plan for expansion and the improvements of facilities for the better service of the public without losing the benefit of exemption. This argument may merit serious consideration, but it should be addressed to the legislature rather than to the courts."

In 1945, it was indicated, the hospital earned a surplus of income over expenses of $86,609; for 1946, the surplus was $106,603—slightly in excess of 8 per cent of gross income. The surplus was mingled with other cash on hand and used for debt retirement and expansion, the court noted. For example, $60,000 of the 1946 surplus was used to build and equip an x-ray department.

"It is conceded that plaintiff operated its hospital properties with the intent of producing, if possible, a surplus of income over expenses so as to permit the periodic retirement of a portion of its bonded indebtedness and to permit the expansion of its facilities," the court stated. "It is further conceded that it had succeeded and was succeeding in accomplishing this purpose. Defendant (city of Sacramento) argues that by reason of plaintiff's profit making intent and purpose, the allowance of the claimed exemption would run counter to the statutory condition that such property be 'not used or operated by the owner for profit regardless of the purposes to which the profit is devoted.'"

Taking up a definition of profit, the court defined it in the dictionary sense as "acquisition beyond expenditure," or "excess of value received over cost." In relation to tax laws, the court held, the phrase "conducted for profit," or "operated for profit" is generally held "to convey the meaning of operated or conducted for the purpose of making a profit." The test indicated by such phrases, the court stated, "is not necessarily whether there is or may be a profit but whether the claimant is operated or conducted for the purpose of making a profit; that is, whether the charges are fixed with the intention of yielding a surplus over and above operating expenses. It thus appears that plaintiff can find little comfort in the ordinary meaning of the word 'profit' or in the construction which has been given to the phrase 'conducted for profit.'" Referring to the Revenue and Taxation Code, the court said, "It appears that the legislature adopted a different concept of 'profit' . . . by providing that the nonprofit requirement could not be satisfied merely by devoting the net earnings to exempt (hospital) purposes."

Interpreting the decision for California hospitals, a newsletter of the California Hospital Association said the

NEWS...

court had construed the Revenue and Taxation Code "as denying the right of exemption of real property taxes if an intentional surplus of income over expenses results from the operation of the hospital. Use of such surplus for the retirement of existing indebtedness or expansion is immaterial."

Anticipating that its petition for rehearing would be denied, in view of the fact that the court's decision was unanimous, the association concluded, "It is not necessary to add that the association's principal legislative program for 1953 will be the amendment of subsection 3, section 214 of the Revenue and Taxation Code."

28 Lawsuits Against Effingham Hospital Settled

EFFINGHAM, ILL.—Twenty-eight lawsuits, which arose from the fire April 4, 1949, at St. Anthony's Hospital here, were settled recently for $425,000.

The Hospital Sisters of the Third Order of St. Francis, operator of the hospital, was the defendant in the case. The plaintiffs had waived the right to collect from other than insurance funds.

The suits involved 34 persons and estates, of whom 22 died in the fire and 12 were injured. Included also were two suits that had been filed at Springfield.

Because of an Illinois supreme court ruling that charitable corporations, such as hospitals, were not liable for negligent acts of employes, the suits were originally filed in the federal district court. However, the high court reversed this position in 1950, after which the suits were refiled in state courts.

Cornell Marks Anniversary

NEW YORK.—One of the great challenges confronting hospital administration today is "the need for developing surroundings and practices in the hospitals that will tie in with the experience at home and strengthen, rather than lessen, family ties," Katharine F. Lenroot, former chief of the U.S. Children's Bureau, stated recently.

Speaking at the 75th anniversary celebration of the Cornell University-New York Hospital School of Nursing, Miss Lenroot said:

"Experiments in the appropriate use of 'natural childbirth,' the 'rooming in' method and the participation of the father in the experience of maternity are all cases in point."

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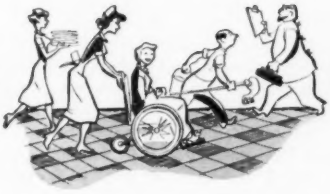

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NEWS...

New York Hospitals Add 1062 Beds, Report Shows

NEW YORK.—New York City hospitals and related facilities reported a total of 47,475 beds on Jan. 1, 1952, or 1062 more beds than the previous year, the Hospital Council of Greater New York's annual inventory revealed.

Mrs. Francisca K. Thomas, acting executive director of the hospital council, stated:

"The beds for general care, which totaled 33,463 on Jan. 1, 1952, constituted 70.5 per cent of the beds in hospitals and related facilities in the city. The number of beds in this major group were 89 more than on Jan. 1, 1951."

"The increase of 1062 beds," Mrs. Thomas continued, "occurred primarily in these fields: convalescence and rehabilitation, chronic disease, and tuberculosis. The bed increases in these fields were 218, 268, and 486 respectively."

V.A. Rules on Treatment for Korean Veterans

WASHINGTON, D.C.—The Veterans Administration has announced that veterans of Korea who need outpatient treatment for disabilities that are presumed to have resulted from their service will be provided this treatment until V.A. can determine whether their disabilities actually are service-connected.

This procedure, V.A. stated, is designed to prevent any delay in furnishing outpatient treatment for such veterans, and applies only to veterans who served in the active U.S. military or naval forces on or after June 27, 1950, and before a date yet to be set.

Under existing regulations, outpatient treatment may be given only for service-connected disabilities after V.A. has determined that the disabilities actually are service-connected and then has authorized the treatment.

Start Recruitment Drive

DETROIT.—An extensive nurse recruitment campaign will be conducted here this fall by the Detroit Council on Community Nursing in cooperation with the Michigan Nursing Center Association, it was announced last month. The campaign will be conducted by the Cunningham Drug Company Foundation. Its director will be Mrs. Mary K. Mullane, associate professor and assistant dean at Wayne University College of Nursing here.

NEWS...

Greater Detroit Hospital Fund Raising Campaign Reaches $20,000,000 Mark

DETROIT. — The Greater Detroit Hospital Fund has announced that its $19,720,000 campaign objective has been oversubscribed and the $20,000,000 mark has been reached.

A surplus of $400,000, representing income from Hospital Fund investments, will be available for distribution to the 14 participating hospitals.

James B. Webber Jr., fund president, stated that it was "the largest sum sought or achieved in a federated hospital campaign anywhere in the country or in the world."

"As soon as details have been completed for collecting the last of the pledges and making final disbursements to the participating hospitals," he continued, "the Greater Detroit Hospital Fund will have fulfilled every phase of the responsibility for which it was created and will then go out of existence."

Contributions are being put to immediate use in creating urgently needed additional hospital facilities for the Greater Detroit area, Mr. Webber pointed out, and four new hospitals already have been finished, several of the expansion projects are completed, and the rest are in various stages of actual construction or are about to begin. Approximately 2000 additional beds for patients and facilities for diagnosis, therapy, professional education and research will be supplied through the program.

An over-all investment of $35,000,000 is represented in the 14 projects, Mr. Webber said, with additional monies coming from reserves of individual hospitals and from other sources to supplement allocations by the fund. The total cost of the program was $60,000,000.

Participants in the fund are: Children's, Cottage, Detroit Osteopathic, Florence Crittenton, Grace Northwestern, Harper, Mount Carmel Mercy, Oakland, Oakwood, Providence, St John, Sinai, Woman's, and St. Joseph Mercy in Pontiac.

Admission of Osteopaths to Staff Causes Controversy

BAY CITY, MICH. — Following the opening, by the city commission, of the city-owned Bay City General Hospital here to osteopaths, the osteopaths held an emergency meeting to form a staff of 25 physicians, surgeons and therapists to handle the cases at the hospital, it was reported recently in the Detroit *Free Press*.

As a result of the controversy between the medical doctors and the osteopaths of the city, the *Free Press* stated, the hospital's patient population dropped from a normal 110 patients to 72, less than half its capacity. Patients of the medical doctors were moving out faster than the osteopaths' patients were moving in, because the medical doctors, all members of the Bay City Medical Society, resolved to send no more patients to the institution on the grounds that the hospital would lose its Class A rating in the American and Michigan hospital associations.

The Michigan Osteopathic Hospital Association, on the other hand, has thrown its support behind the Bay City osteopaths and has promised men and equipment, if necessary, the *Free Press* reported.

NEWS...

A.C.H.A. Announces Scholarship Loan Plan

CHICAGO.—The American College of Hospital Administrators recently made available revolving scholarship loans to encourage deserving persons to pursue careers in hospital administration and to contribute to the improvement of hospital administration generally.

The loan will be offered to both nonaffiliates and affiliates of the college and will make it possible for promising candidates to take courses in hospital administration at about 13 universities at which the subject is offered.

The college plans to make limited sums available annually to persons in the hospital field who will agree to repay the amounts on terms established by the college's scholarship committee. Candidates for loans are required to have a baccalaureate degree or its equivalent in education or experience, it was explained.

Toronto Residencies Listed

TORONTO, ONT.—Administrative residencies have been assigned to the following graduates in hospital administration from the University of Toronto School of Hygiene:

Norman K. Barr, Royal Jubilee Hospital, Victoria, B.C.; Omer H. Clusiou, Hamilton General Hospital, Hamilton, Ont.; Stanley D. Krawchuk, unassigned; J. Douglas McMillan, Regina General Hospital, Regina, Sask.; Douglas M. McNabb, Vancouver General Hospital, Vancouver, B.C.; Kerle G. Palin, Kingston General Hospital, Kingston, Ont.; Philip A. Sheridan, Toronto Western Hospital, Toronto, Ont.; J. Sydney Renton, Victoria Hospital, London, Ont.; C. Kenneth Temple, Toronto East General Hospital, Toronto, Ont.; Dr. John Thompson, Royal Alexandra Hospital, Edmonton, Alta., and Elmer W. Roeder, Kitchener-Waterloo Hospital, Kitchener, Ont.

Ward Administration Course

CLEVELAND.—The Frances Payne Bolton School of Nursing of Western Reserve University will again offer its special five-week course in ward administration from October 13 to November 14.

In addition to studying ward level administration, participants in the course will examine factors contributing to current changes in nursing practice. Registration is limited to nurses engaged in administrative work, or those who are expecting to assume such responsibilities.

Bulletin Reports Demand for Specially Equipped Centers for Prematures

NEW YORK.—Premature babies taken to hospital centers especially equipped for their care have a better chance for survival than do such premature babies in general, reported the Hospital Council of Greater New York.

The council, in a recent *Bulletin*, stated that of those babies born in 1949 who weighed less than 1000 grams at birth, 95.3 per cent died in the first month of life. "The neonatal mortality of premature babies of similar weight who were transported to special centers was 70.2 per cent. In the weight group 1000 to 1499 grams, these percentages were 45.4 and 23.4, respectively . . . . Of all babies weighing 1500 to 1999 grams at birth, 16.4 per cent died under one month of age; of those transferred to centers, 12.4 per cent died.

The *Bulletin* noted that there has been an increasing demand for the transfer of premature infants to centers and that the centers can no longer meet the demand. "During the year 1951, there were 995 requests, and 755 babies, or 75.9 per cent, were transferred."

Upon completion of special centers now under construction, 11 hospitals will provide this service, with a total of 331 bassinets for the care of premature infants.

Referring to facilities for these babies in Brooklyn, the council stated, "Although one center, at Kings County Hospital, is being completed with the aid of federal funds, there is no voluntary hospital offering this service in that borough."

The *Bulletin* pointed out that "the hospital council has been a strong advocate of the program for establishing special centers in selected hospitals for the care of premature infants. . . . It looks forward to the further development of this essential service, which is designed to save lives among the smallest members of the community."

COMING EVENTS

AMERICAN ACADEMY OF PEDIATRICS, Palmer House, Chicago, Oct. 20-23.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Shoreham Hotel, Washington, D.C., Oct. 13-17.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Benjamin Franklin Hotel, Philadelphia, Sept. 14, 15.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Fellows' Seminar, University of Michigan, Ann Arbor, Dec. 5-8.

AMERICAN COLLEGE OF SURGEONS, Waldorf Astoria Hotel, New York City, Sept. 22-26.

AMERICAN CONGRESS OF PHYSICAL MEDICINE, Roosevelt Hotel, New York City, Aug. 25-29.

AMERICAN DIETETIC ASSOCIATION, Municipal Auditorium, Minneapolis, Oct. 21-24.

AMERICAN HOSPITAL ASSOCIATION, Philadelphia, Sept. 15-18.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, Schroeder Hotel, Milwaukee, Aug. 9-16.

AMERICAN PHARMACEUTICAL ASSOCIATION, Bellevue-Stratford Hotel, Philadelphia, Aug. 17-23.

AMERICAN PUBLIC HEALTH ASSOCIATION, Cleveland Hotel, Cleveland, Oct. 20-23.

CALIFORNIA HOSPITAL ASSOCIATION, Mar Monte Hotel, Santa Barbara, Nov. 6, 7.

COLORADO HOSPITAL ASSOCIATION, Cosmopolitan Hotel, Denver, Nov. 6, 7.

CONNECTICUT HOSPITAL ASSOCIATION, Auditorium, Southern New England Telephone Co., New Haven, Nov. 18.

ILLINOIS HOSPITAL ASSOCIATION, Abraham Lincoln Hotel, Springfield, Nov. 20, 21.

INSTITUTE ON LAUNDRY, Sheraton Hotel, Detroit, Oct. 13-17.

INSTITUTE ON NURSING SERVICE, San Francisco, Oct. 13-17.

INSTITUTE ON PURCHASING, Sheraton Hotel, St. Louis, Nov. 10-14.

INSTITUTE ON ACCOUNTING, Knickerbocker Hotel, Chicago, Nov. 10-14.

INSTITUTE FOR MEDICAL RECORD LIBRARY PERSONNEL, Radisson Hotel, Minneapolis, Nov. 10-14.

INSTITUTE ON HOUSEKEEPING, St. Charles Hotel, New Orleans, Dec. 1-5.

INSTITUTE ON NURSING SERVICE ADMINISTRATION, Knickerbocker Hotel, Chicago, Dec. 8-12.

INTERNATIONAL CONGRESS ON MEDICAL RECORDS, London, England, Sept. 7-12.

KANSAS HOSPITAL ASSOCIATION, Town House, Kansas City, Nov. 6, 7.

MANITOBA HOSPITAL ASSOCIATION, Royal Alexandra Hotel, Winnipeg, Oct. 22-24.

MARYLAND - DISTRICT OF COLUMBIA - DELAWARE HOSPITAL ASSOCIATION, Hotel du Pont, Wilmington, Del., Nov. 10, 11.

MICHIGAN HOSPITAL ASSOCIATION, Statler Hotel, Detroit, Nov. 16-18.

MISSOURI HOSPITAL ASSOCIATION, Hotel Jefferson, St. Louis, Nov. 20, 21.

MISSISSIPPI HOSPITAL ASSOCIATION, Heidelberg Hotel, Jackson, Oct. 16, 17.

NATIONAL ASSOCIATION OF CLINIC MANAGERS, Palmer House, Chicago, Sept. 28-Oct. 1.

NEBRASKA HOSPITAL ASSOCIATION, Pathfinder Hotel, Fremont, Nov. 13, 14.

OKLAHOMA STATE HOSPITAL ASSOCIATION, Skirvin Hotel, Oklahoma City, Nov. 6, 7.

ONTARIO HOSPITAL ASSOCIATION, Royal York Hotel, Toronto, Oct. 27-29.

OREGON ASSOCIATION OF HOSPITALS, Pilot Butte Inn, Bend, Oct. 20, 21.

RHODE ISLAND HOSPITAL ASSOCIATION, Miriam Hospital, Providence, Dec. 13.

SOUTH DAKOTA HOSPITAL ASSOCIATION, Alex Johnson Hotel, Rapid City, Oct. 6, 7.

VERMONT HOSPITAL ASSOCIATION, Pavilion Hotel, Montpelier, Oct. 29, 30.

WASHINGTON HOSPITAL ASSOCIATION, Cascadian Hotel, Wenatchee, Oct. 22, 23.

WOMEN'S HOSPITAL AUXILIARIES, Warwick and Barclay Hotels, Philadelphia, Sept. 15-18.

WYOMING HOSPITAL ASSOCIATION, Memorial Hospital, Rock Springs, Sept. 26, 27.

1953

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Palmer House, Chicago, Feb. 10-13.

MASSACHUSETTS HOSPITAL ASSOCIATION, Sheraton Plaza Hotel, Boston, Jan. 20.

NATIONAL ASSOCIATION OF METHODIST HOSPITALS AND HOMES, Palmer House, Chicago, Feb. 11, 12.

OHIO HOSPITAL ASSOCIATION, Netherland Plaza Hotel, Cincinnati, April 6-9.

NEWS...

Greater New York Council Condemns Segregation

NEW YORK.—The Hospital Council of Greater New York recently endorsed the action of the Medical Society of the County of New York, which has passed a resolution condemning "the practice of discrimination or segregation in appointments to hospital staffs and internships."

The council expressed the hope that "hospital boards of trustees, physicians and the public will work together to the end that doctors now without hospital connections may attain appointments which will give them, under appropriate supervision, the educational experience afforded by work in wards and outpatient departments and the privilege of caring for private patients."

"If all practicing physicians had such hospital opportunities," the council stated, "the recipient of medical care, the general public, would benefit."

New Jersey Associations Approve New Press Code

TRENTON, N.J.—The boards of trustees of both the New Jersey Press Association and the New Jersey Hospital Association have approved a code that will act as a standard in the relationship between hospitals and the press.

The first section of the code, which deals with newspapers, states that the press should: (1) refrain from any action or demands that might jeopardize the patient's life or health or which might prevent or interfere with the giving of care by hospital personnel to the patient; (2) check and confirm all information concerning the hospital or its patients, and check quotations for accuracy, both as to content and as to context; (3) judge carefully material which might harm the patient or which might, without factual basis, weaken the confidence of the public in the hospital; (4) respect the privacy and legal rights of a patient and not jeopardize the hospital-patient relationship, and (5) use only authentic information from hospital authorities in publishing stories of medical research, unusual operations, or new procedures.

The code states that hospitals should: (1) designate spokesmen competent to give authentic information to the press at any time without the necessity of clearing with higher authority; (2) extend equal courtesy and cooperation to

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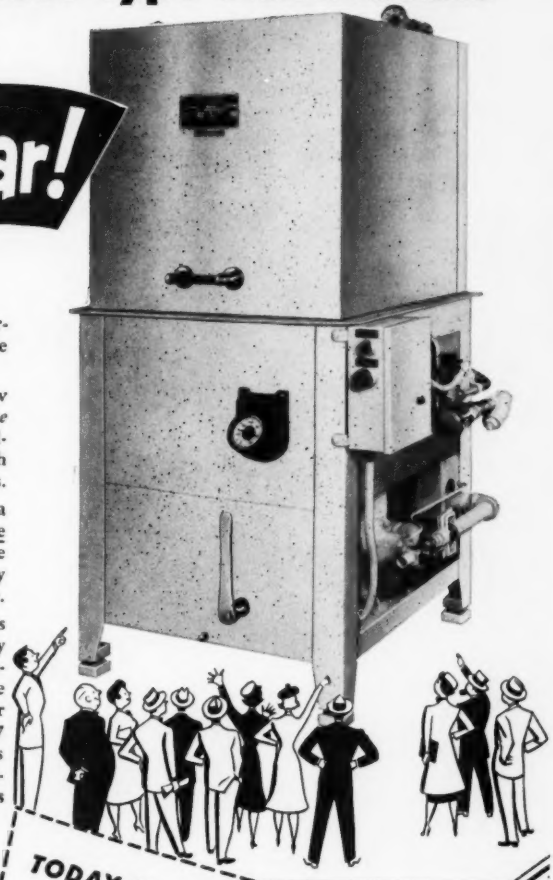

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all newspapers; (3) cooperate in giving information and in obtaining interviews and consent for pictures, provided that the welfare, privacy, or legal rights of the patient are preserved; (4) identify the patient, give the general nature of injuries, when ascertained, and the degree of seriousness in cases of accident or other emergency, and, in matters not of public record, comply with newspaper requests in individual cases for the name of the patient and the attending physician if the patient and the physician agree, and (5) carefully refrain from giving information on hospital procedures, equipment, facilities for treatment, or other features of hospital service by implying that such facilities or features exist only in the hospital named unless it is the ascertained fact.

50 Grams of Radium Installed in Clinic

NEW YORK.—Dr. Madison B. Brown, executive vice president and medical director of Roosevelt Hospital here, has announced that a unit containing 50 grams of radium is now installed in the Henry Harrington Janeway Clinic for Therapeutic Radiology, a new underground department of the hospital, built especially for the radium.

Dr. Douglas Quick, surgeon and therapeutic radiologist, is director of the clinic. Dr. Gioacchino Failla and Dr. Edith Quimby, professor and associate professor, respectively, of the Radiological Research Laboratory, College of Physicians and Surgeons, Columbia University, are consulting physicists.

The $1,000,000 element, which has been loaned to the hospital by the Union Miniere du Haut Katanga of Brussels, is in a special structure, designed by Dr. Failla, which works on a new principle of treatment termed converging-beam radium therapy. The method minimizes the amount of skin damage and increases the efficiency of radiation delivered to a deep seated tumor.

Public Health Service Names Study Committee

WASHINGTON, D.C.—The U.S. Public Health Service recently appointed 17 leaders in the public health field as a consultant committee to a two-year study on the amount and kind of nursing service required to meet minimum public health needs.

Dr. Marion Ferguson, who has been assigned to the division of public health nursing to conduct the nursing analysis, said the study would supplement a broad functional study of the nursing profession now being made by the American Nurses' Association.

She listed as some of the questions to which her group would try to find the answers: (1) the amount of additional nursing service required in the rapidly growing defense areas; (2) how the available nursing supply could be "stretched" to meet the growing needs, and (3) the use of practical nurses or other aides in the public health program.

$18,100 Granted by Kellogg for Practical Nurse Training

BATTLE CREEK, MICH.—The W. K. Kellogg Foundation has granted $18,100 to the Illinois board of vocational education for the promotion of practical nurse training.

The grant, which will enable the board to add a state supervisor of prac-

Now under construction, New Rochelle Hospital's West Wing, to include a laundry plant where yearly over four million pieces of linen will be washed.

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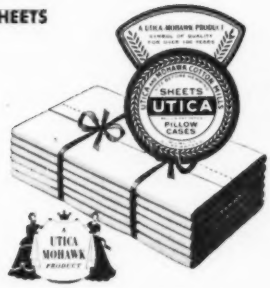

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tical nursing to its staff, will provide the entire financial support for this position in the first two years. During the third year the state will contribute $2600 and thereafter will assume the full responsibility for the continuation of the post.

The state board of vocational education is planning, with the help of the new supervisor, to set up three or four training centers in various parts of the state during 1951-52. Chicago has the only center at present. In 1952-53 it expects to establish a half-dozen more centers for preparatory training and perhaps twice that number for extension classes. Additional centers also are planned for 1953-54.

New York Hospitals Offer Comprehensive Program of Rehabilitation Services

NEW YORK.—New York City is the only community in the United States where comprehensive rehabilitation services are available in municipal general hospitals, it was reported recently.

Of the first 1600 general hospitals, including both municipal and voluntary, replying to a questionnaire sent out last summer by the Commission on Chronic Illness, only 65 reported they operated organized rehabilitation services; 18 reported they had special rehabilitation wards.

New York's rehabilitation service started in 1946 with two 40 bed wards in Bellevue Hospital. The program of the city's Department of Hospitals now includes 349 beds with units in Bellevue, City, Goldwater Memorial, Kings County and Metropolitan hospitals.

Dr. Marcus D. Kogel, commissioner of hospitals, reported that this program will be expanded in the next two years. It will be accomplished by opening 22 beds at Fordham Hospital, which will be transferred to the Bronx Hospital Center when it opens. Also, the number of beds at Queens General Hospital will be increased from 30 to 40 and there will be 400 beds in the new Bird C. Coler Hospital, now under construction on Welfare Island. The latter unit will then absorb the units now operating at Metropolitan and City hospitals.

V.A. Recommends Two-Year Residency and Training for Hospital Pharmacists

WASHINGTON, D.C. — The Veterans Administration's special pharmacy training committee has recommended a two-year hospital pharmacy residency and academic training program for V.A. hospitals.

The program's activation will depend upon formal approval and development of administrative procedures and operational details.

Under the plan, registered recent pharmacy graduates holding B.S. degrees would be selected for training. The group then would be enrolled in graduate schools of affiliated colleges or universities to pursue study leading to a master's degree in pharmacy. Concurrently with their studies they also would receive on-the-job training which would include phases of hospital pharmacy operations, such as inpatient and outpatient dispensing, manufacturing and general administration in V.A. hospitals. These instructions would be supervised by the chief pharmacists at the activities.

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phase of the over-all program, the committee said, would conform to those developed by the American Society of Hospital Pharmacists and approved by the division of hospital pharmacy of the American Pharmaceutical Association. A certificate has been recommended showing the successful completion of this phase of the program.

Medical Educators Criticize Stress on Technical Skills in Premedical Schools

BUCK HILL FALLS, PA.—The tendency of premedical education to stress technical skills as opposed to cultural values was criticized here recently at a conference on preprofessional education in which delegates representing more than 100 colleges, medical schools, and educational organizations were present.

The study of preprofessional education is being carried out under the survey of medical education that has been conducted during the last two years by the Association of American Medical Colleges and the Council on Medical Education and Hospitals of the American Medical Association.

Addressing the conference here, Dr. Gilbert White, president of Haverford College, said increased emphasis on specialization, in addition to demands of the military services, had so lengthened the span of medical training that premedical students preferred acceleration of practical training to emphasis on liberal arts education in the premedical years.

At the same time, Dr. White pointed out "the apparent threat to national and international security has caused many Americans to look more carefully to the intellectual and spiritual roots by which their free society has flourished.

"Such a free society needs many technical specialists, but it has no essential need for the specialist who is only a technologist. It must have many men and women concerned with the strengthening of its policies of liberal thought and action."

Dr. Aura E. Severinghaus, associate dean of the faculty of medicine at Columbia University, discussed the purposes of the conference.

She reported that a survey that has been under way since 1950, when completed, would show a "widespread revival of interest in traditional objectives of the Nineteenth Century, when it was felt to be the chief duty of the university to produce good citizens, leaders in affairs and in professions."

But, she added, the present crisis has "intensified the trend toward technology" and "unless we can keep pace with it with our moral development, we will destroy ourselves."

ABOUT PEOPLE

(*Continued From Page* 92)

Paul H. Keiser

Paul H. Keiser has been named administrator of the Community Hospital of Evanston, Ill., which is scheduled to open in September. Mr. Keiser, a graduate of the program in hospital administration from Northwestern University, served his administrative residency at Wesley Memorial Hospital, Chicago, and was concurrently administrative assistant. **Violet Hunter, R.N.,** who has been superintendent of Community Hospital since 1936, will become director of nurses of the hospital, upon removal to the new facility. She will continue as superintendent of the present unit until that time.

Dr. Ferdinand Haase Jr. has been appointed to fill the position of medical director of Albany Hospital, Albany, N. Y., which has been vacant since 1946. Dr. Haase, who begins his new duties in September, is currently executive director of the Nathan Littauer Hospital, Gloversville, N.Y., and previous to that was assistant director of Massachusetts General Hospital, Boston.

Irene E. Oliver has resigned as administrator of Tompkins County Memorial Hospital, Ithaca, N.Y., to assume the post of administrator, Magic Valley Memorial Hospital, Twin Falls, Idaho.

William P. Ryan Jr., a graduate of the course in hospital administration, School of Public Health, Columbia University, has been appointed assistant administrator, Meriden Hospital, Meriden, Conn. Mr. Ryan served as administrative resident at Hartford Hospital, Hartford, Conn.

Frank McPherson is the newly appointed superintendent of Miner's Hospital, Christopher, Ill.

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Dr. August H. Groeschel, assistant director of New York Hospital, New York City, has been appointed director of the Philadelphia General Hospital, Philadelphia.

Larry D. McIntyre is the new administrator at Prosser Memorial Hospital, Prosser, Wash., succeeding **Hugh A. Moeller,** who is taking charge of the new Stillwater Community Hospital, Columbus, Mont., for the Northwest Hospital Consultants, Spokane, Wash. Mr. McIntyre's successor as superintendent at Okanogan County Hospital District No. 1, Brewster, Wash., is **Howard M. Gamble.**

Dr. Horace B. Cupp, manager of the Veterans Administration Hospital, Chamblee, Ga., since 1947, has been appointed manager of the V.A. Hospital at Durham, N.C., which is scheduled to open in November. The hospital will be affiliated with Duke University School of Medicine.

Lulu Swope has resigned as manager of Asotin County Memorial Hospital, Clarkston, Wash. Mrs. Swope's successor is **Mrs. M. A. Denham, R.N.**

Noel M. Jeffrey, manager of the Veterans Administration Hospital, Vancouver, Wash., has been appointed to a similar post at the V.A. Center at Wichita, Kan. Mr. Jeffrey succeeds **Bert C. Moore,** whose appointment as manager of the V.A. Center at Dayton, Ohio, was announced in the July issue of The MODERN HOSPITAL.

B. Lee Mootz is the new administrative assistant at Aultman Hospital, Canton, Ohio. His appointment became effective July 1. Mr. Mootz, who has just completed his one-year administrative residency at the hospital, attended the University of Minnesota and Ohio State University, and was graduated from the University of Chicago.


Sherwood Smith

Sherwood Smith has been named assistant administrator of the Hubbard Memorial Hospital, Nashville, Tenn. A graduate of the Duke University course in hospital administration, he has just completed a two-year residency at Hubbard.

Aaron B. Cohen has been named to succeed **Moses Wachs** as assistant executive director of the Home and Hospital of the Daughters of Jacob, New York City. Mr. Wachs has been appointed superintendent of the new 400 bed Parshelsky Pavilion, which is a branch of the Brooklyn Hebrew Home and Hospital for the Aged, New York City. Mr. Cohen formerly was director of social service at the Home and Hospital of the Daughters of Israel, New York City.

Leon C. Carson has been appointed administrative assistant at Robert Packer Hospital, Sayre, Pa. Mr. Carson, who served his residency in hospital administration at the Robert Packer Hospital, is a graduate of the hospital administration course at Columbia University.

Elvin Lee Gronemyer has been appointed administrator of Pioneer Memorial Hospital, Heppner, Ore., succeeding **John Ernsdorff.** Mr. Gronemyer formerly was associated with the Seattle Scientific Supply Company.

Gerard H. Smith has succeeded **Clara Coleman, R.N.,** as administrator of The Dalles General Hospital, The Dalles, Ore.

Dr. Ellsworth T. Neumann, formerly assistant director of Massachusetts General Hospital, Boston, has been appointed executive officer for the entire hospital. **Dr. Charles L. Clay** is now assistant

director at the hospital, and **Henry J. Murphy,** the former administrative assistant in charge of housekeeping and laundry, is the new assistant director for the entire hospital.

Paul Bliss has assumed the duties of administrator at Vancouver Memorial Hospital, Vancouver, Wash. Mr. Bliss' former post as credit and office manager of Vancouver Memorial, has been assumed by **David Mobley.**

Jack Warren Shrode, formerly administrator of Winkler Memorial Hospital, Kermit, Tex., has been named administrator of Wesley Hospital, Oklahoma City, succeeding **Harry C. Smith.** Mr. Shrode received a master's degree in hospital administration from Washington University in 1949 and spent his administrative residency at Harris Hospital, Fort Worth, Tex. He also spent a year as administrative assistant at Protestant Deaconess Hospital, Evansville, Ind.

William L. Stollmack is the new business manager of St. Charles Hospital, Bend, Ore., succeeding **Walter J. Eagan.**

Elizabeth Schrei, R.N., is the newly appointed administrative assistant at Galesburg Cottage Hospital, Galesburg, Ill. Miss Schrei, who received her master's degree in hospital administration from Northwestern University, served her administrative residency at Galesburg.

Edmund R. Mattos has resigned as administrator of the New England Hospital, Boston, to accept a position as assistant director at the Massachusetts General Hospital, Boston. Mr. Mattos is a graduate of the Yale University course in hospital administration and is a nominee of the American College of Hospital Administrators.

Paul Elbow has assumed his new duties as administrative assistant at St. Mary's Hospital, Racine, Wis. Mr. Elbow is a graduate of Northwestern University's course in hospital administration and has completed a term as resident administrator at the Baptist Hospital in Evansville, Ind.

Dr. Charles Buckman, assistant commissioner of the New York State Department of Mental Hygiene since 1950, is now senior director of Kings Park State Hospital, Kings Park, N.Y., succeeding **Dr. Arthur E. Soper,** who retired recently. **Dr. James A. Brussel,** assistant director of Willard State Hospital, Willard, N.Y., has been named to the vacated post of assistant commissioner. In the state hospital service since 1923, Dr. Buckman was director of Gowanda State Hospital from 1949 until he was appointed assistant commissioner. He is a diplomate of the American Board of Psychiatry, and a member of the American Psychiatric Association and the American Medical Association. Dr. Brussel, who from 1940 to 1946 served as chief of various neuropsychiatric services in army hospitals, holds diplomas in both neurology and psychiatry from the American Board of Psychiatry and Neurology. He is a fellow of the American College of Physicians, the American Medical Association and the New York Academy of Medicine.

Frederick D. Squire has resigned as assistant to **F. G. Bruesch,** administrative assistant at Harper Hospital, Detroit, to accept the post of purchasing agent and personnel director at Oakwood Hospital, Dearborn, Mich.

Joe Kreycik has accepted the position of consultant-administrator at Henry County Hospital, Paris, Tenn. Until recently Mr. Kreycik was a student in the school of hospital administration at Northwestern University.

Herman F. Zimoski Jr., who recently resigned as administrator of Memorial Hospital, Colorado Springs, Colo., has been appointed administrator of the Door

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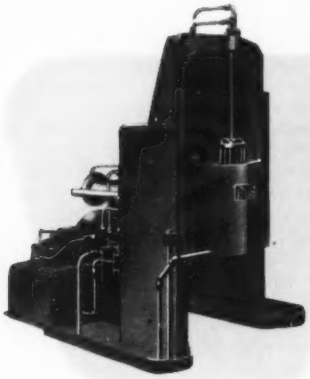

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County Memorial Hospital, Sturgeon Bay, Wis. In his new post he succeeds **Gerhard A. Krembs,** whose appointment as administrator of the Ishpeming-Negaunee Hospital, Ishpeming, Mich., was announced in the June issue of The Modern Hospital. The appointment of **Walter D. Golding** as Mr. Zimoski's successor at Colorado Springs was announced in the March issue of The Modern Hospital.

Department Heads

Neal R. Johnson, purchasing agent of Johns Hopkins Hospital, Baltimore, for the last 29 years, has retired. He will be succeeded by **Hubert M. Johnson,** who joined the Hopkins staff as assistant purchasing agent last October. Neal Johnson will continue active in the field as a consultant and in the writing of specifications for the purchase of equipment and supplies. Hubert M. Johnson, a graduate of the course in hospital administration, Duke University, was assistant director of James Walker Memorial Hospital, Wilmington, N.C., prior to joining the Hopkins staff.

Marshal S. Cherkas is the new purchasing agent at Mount Sinai Hospital of Greater Miami, Miami Beach, Fla. Mr. Cherkas recently completed a one-year residency in hospital administration at Mount Sinai, in cooperation with Northwestern University's program in hospital administration.

Cora McChesney has assumed her new duties as executive housekeeper of Middletown Hospital, Middletown, Ohio. She formerly held a similar position at Norton Memorial Infirmary, Louisville, Ky.

Barbara Cowles has been appointed to the position of medical librarian at the Robert Packer Hospital, Guthrie Clinic, Sayre, Pa.

Alma C. Norum assumed her new duties July 1 as director of nurses at Lutheran Deaconess Hospital, Chicago. She formerly was assistant to the director in the bureau of education and registration in Nebraska.

Henry Kutsch has been named personnel administrator at Passavant Memorial Hospital, Chicago. For the last two years Mr. Kutsch has been associated with Brown's Business College, Peoria, Ill., where he taught personnel administration, economics, sales administration and allied business subjects.

Ada A. Fields has been appointed chief medical record librarian at the Robert Packer Hospital, Guthrie Clinic, Sayre, Pa. She formerly was medical record librarian at the Dover General Hospital, Dover, N.J.

John J. Carr is the newly appointed head of the dietary department at Albany Hospital, Albany, N.Y., succeeding **Robert P. Bryant.** Mr. Carr joined the Albany staff in 1951 and has assisted Mr. Bryant in the operation of the department for the last year. He received his B.S. degree from the College of Hotel Administration at Cornell University in 1950.

Virginia M. Dunbar, who has held the two posts of dean of the Cornell University-New York Hospital School of Nursing and director of the New York Hospital Nursing Service since 1946, will relinquish the latter post and devote her full time to the nursing school. **Muriel Carbery,** associate director of the nursing service, will become its director.

Dr. Gardner Middlebrook has been named director of research and laboratories at the National Jewish Hospital, New York City, succeeding **Dr. Harry J. Corper,** who has retired after 32 years. Dr. Middlebrook formerly was associate in the department of pathology and microbiology at the Rockefeller Institute for Medical Research.

Helen M. Bardes, R.N., is the newly

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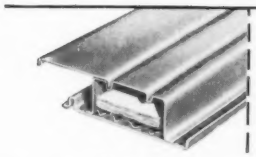

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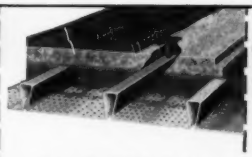
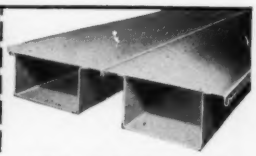


Acoustical Holorib for acoustical-structural roof. Width 18". Depth 1½".



"D" Panels for floors, roofs, ceilings. Standard width 16". Depth 1½" to 7½".

appointed director of nursing service for the Valley Children's Hospital and Guidance Clinic, Fresno, Calif., effective July 15. Miss Bardes has specialized in nursing education during the last 10 years, and has held nursing appointments at Stanford University Hospitals and at Children's Hospital in San Francisco.

Lois Millaire Albert has been appointed executive housekeeper at Norton Memorial Infirmary, Louisville, Ky. She formerly held a similar post at the Hospital for Joint Diseases in New York City.

Dorothy M. DeHart, chief dietitian, Roosevelt Hospital, New York City, for more than 22 years, has tendered her resignation.

Miscellaneous

Dr. Thomas L. Hagan has been named chief of the division of dental public health in the Federal Security Agency, succeeding **Dr. John W. Knutson,** who has been named chief dental officer of the Public Health Service.

Hazel Shortal has been assigned to assist in the cooperative public health programs in Latin America as a staff member of the Institute of Inter-American Affairs.

Judith Gage Whitaker, R.N., is the newly appointed associate executive secretary of the American Nurses' Association. She has served as executive secretary of the Nebraska State Nurses' Association, as well as executive secretary and registrar of District 2 of the N.S.N.A. A former public health nurse with the Omaha Visiting Nurse Association, since 1950 she has been part-time assistant executive secretary of the A.N.A., assigned to the public relations unit.

Earl H. Kammer, former assistant executive director of the Hospital Care Corporation, the Blue Cross plan for Cincinnati, has been named associate executive director of the plan.

Trustees

Mrs. Isaac Marcosson has been re-elected president of the Society of Memorial Cancer Center, a volunteer organization serving the Memorial Center for Cancer and Allied Diseases in New York City. Mrs. Marcosson is a founding member of the society and has been associated with the center since 1938.

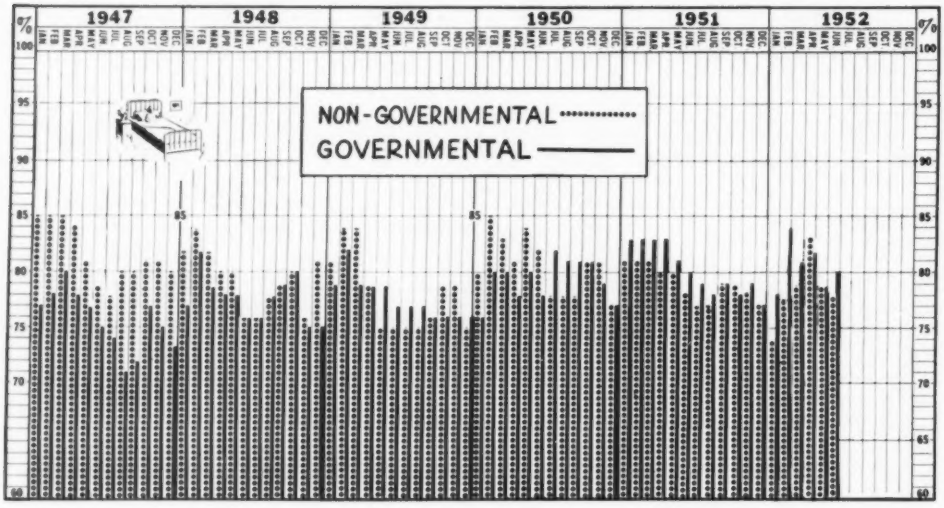
Deaths

Robert Jolly, founder and second president of the Texas Hospital Association, died May 14. Mr. Jolly was administrator of Memorial Hospital, Houston, for 25 years. A charter fellow of the American College of Hospital Administrators, Mr. Jolly served as president of the American Hospital Association, the American Protestant Hospital Association, and the South Texas Hospital Council.

Dr. Olin West, for 23 years secretary and general manager of the American Medical Association until he retired in 1946, died June 22. When Dr. West left the A.M.A. he was its president-elect but did not become president because of ill health. He returned to Nashville, Tenn., where he had previously practiced medicine, and again established a practice. Dr. West also had held the posts of director for the Rockefeller Sanitary Commission and the International Health Board in Tennessee, and secretary and executive officer of the Tennessee State Board of Health.

Dr. Christopher Graham, one of the group of physicians that founded the Mayo Clinic, died June 21 at the age of 96. Dr. Graham became associated with the late **Dr. W. J. Mayo** and the late **Dr. C. H. Mayo** shortly after he received his medical degree in 1894 from the University of Pennsylvania. He retired from medical practice in 1919 after holding several posts with the clinic.

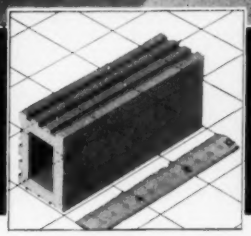
Occupancy Rises in Voluntary Hospitals



For the month of June, governmental hospitals have reported an average daily occupancy of 78.4 per cent, while non-governmental hospitals indicate occupancy to be 80.4 per cent of capacity. Figures reported for the same month last year were 80.1 and 77.6 per cent.

New hospital construction reported for the period ending July 14 totaled $2,606,018, bringing the total for the year to $276,977,882. This compares to a total reported construction of $454,096,000 at this time last year. During the latest 1952 period, 46 new projects were reported at an aggregate cost of $28,680,000. During the same period, however, a number of previously reported projects were postponed.

Interior views showing NATCO Ceramic Glazed Structural Facing Tile (Vitritile) used in LLOYD ST. JOSEPH HOSPITAL, Menominee, Michigan. *Architect*—Harry W. Gjelsteen, Menominee, Michigan. *Contractor*—Proksch Construction Co., Iron River, Michigan.



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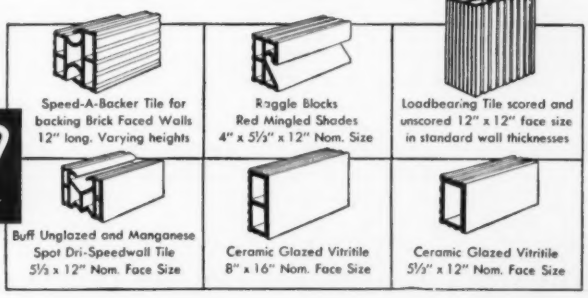

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ACCOUNTANT—B.S., Accounting and Economics; six years, accountant, 600-bed hospital; will consider business managership plus accounting.

ADMINISTRATOR—M.A., Hospital Administration; year's administrative residency, three years administrative assistant, teaching hospital; will consider assistant administratorship, large hospital or directorship, small institution.

ADMINISTRATOR—Lay; Degree in Business Administration, Harvard; eight years, administrative experience, public institutions; six years, director, voluntary 350-bed hospital; FACHA.

ADMINISTRATOR—Medical; MBA, Hospital Administration; several years, assistant administrator, university hospital; eight years, director, voluntary general hospital, 300 beds; FACHA.

(Continued on page 192)

MEDICAL BUREAU—*Continued*

ADMINISTRATOR—B.S., Nursing Education; M.H.A., Hospital Administration; experience includes five years, director of nursing; two years, assistant administrator, 200-bed hospital; recently completed specialized training.

PERSONNEL DIRECTOR—Bachelor's in Business Administration; year's administrative internship, teaching hospital; two years, director of personnel and public relations, 300-bed hospital.

PATHOLOGIST—Diplomate; FCAP; two years, associate pathologist, large teaching hospital; four years, director of laboratories, 300-bed general hospital; in thirties.

RADIOLOGIST—M.S., Radiology; Diplomate, Diagnostic and Therapeutic Radiology, including Radium Therapy; Fellow, American College of Radiology; four years, director of radiology, 275-bed hospital.

POSITIONS OPEN

ADMINISTRATOR—Assistant; progressive Canadian hospital of 226 beds with $5,500,000 expansion program increasing capacity to more than 350 beds, seeks qualified assistant to lay administrator; applicants may be medical or lay, but must have background of administrative experience and good personality; position offers excellent opportunity for advancement. Apply, Superintendent, Jewish General Hospital, 3755 Cote St. Catherine Road, Montreal 26, Canada.

ANESTHETIST—110-bed hospital; work light; live in or out; salary $400 plus bonus and percentage on work. Mrs. Probandt, Superintendent, Belmont Hospital, 4058 West Melrose Street, Chicago, Illinois. Pensacola 6-7000.

ANESTHETIST—For 331-bed general hospital; good working conditions, interested staff, salary $350 per month with maintenance. Write to Frank C. Haythorn, Superintendent, Greenville General Hospital, Greenville, South Carolina.

ANESTHETIST—Nurse; 250-bed general hospital; starting salary $300 a month plus full maintenance; vacation, sick leave and holidays. Apply, Ohio Valley Hospital, Steubenville, Ohio.

ANESTHETIST—Nurse; 100-bed approved pediatric hospital; light schedules, liberal personnel policies; maintenance optional; centrally located metropolitan area; salary open. Apply, giving full particulars and when available: Mr. D. O'Neill, Director, Babies' Hospital, 15 Roseville Avenue, Newark, New Jersey.

ANESTHETIST—Nurse; for 250-bed general hospital; excellent working conditions and personnel policies; salary dependent upon experience. Write, wire or call collect, Joseph G. Norby, Administrator, Columbia Hospital, 3321 North Maryland Avenue, Milwaukee, Wisconsin.

ANESTHETIST—Nurse; for 106-bed active hospital in resort area; salary $400 with partial maintenance. Apply to Administrator, Alpena General Hospital, Alpena, Michigan.

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POSITIONS OPEN

ANESTHETIST—Nurse: for new 200-bed AMA and ACS approved general hospital; department headed by anesthesiologist; salary open, dependent upon experience. Write, B. W. Mandelstam, M.D., Administrator, Mount Sinai Hospital, Minneapolis, Minnesota.

ANESTHETIST—Nurse; 240-bed general hospital; excellent working conditions and good personnel policies; salary dependent upon experience. Apply, Administrator, Mercy Hospital, 144 State Street, Portland 3, Maine.

ANESTHETIST—Nurse; AANA; small general hospital. Write, Harry Gerard, Superintendent, Trenton General Hospital, 140 North Clinton Avenue, Trenton, New Jersey.

ANESTHETIST—Nurse; 86-bed hospital; salary open; No. O.B. calls; liberal employee benefits. Apply, Superintendent, Group Health Hospital, 201 16th Avenue North, Seattle 2, Washington.

ANESTHETISTS — Nurse; three immediate vacancies; minimum starting salary $350 with full maintenance; increases every six months first two years; experienced nurse anesthetists, starting salary $400 with full maintenance; 115-bed general hospital, six miles from downtown Washington, D.C. Apply to Administrator, Arlington Hospital, Arlington, Virginia.

ANESTHETISTS—Nurse; for 150-bed community hospital; four nurses, full time M.D., all agents and techniques; good opportunity for advanced training; full maintenance and one month's vacation; two and one-half hours from Boston and New York. Write, G. J. Carroll, M.D., William W. Backus Hospital, Norwich, Connecticut.

ANESTHETISTS—Nurse; two urgently needed; modern, well equipped, 100-bed hospital, employing only graduate staff; attractive location within forty minutes of San Francisco; 5-day week; excellent salary; maintenance available. Administrator, Alameda Hospital, Alameda, California.

ANESTHETISTS — Nurse; two vacancies; A.A.N.A. members; 626-bed general hospital; 10 nurse anesthetists on staff; good salary and hours; liberal personnel policies. Apply, Chief Anesthetist, Good Samaritan Hospital, Cincinnati 20, Ohio.

ANESTHETISTS—Nurse; two vacancies immediately available; full-time medical anesthetist in charge of Department; new, modern 115-bed hospital. Mount Sinai Hospital, Hartford, Connecticut.

DIETITIAN—Wanted for Charlotte County Hospital; position open September 1; new hospital scheduled for completion this fall. Apply, stating qualifications, experience and salary expected to: Superintendent, Charlotte County Hospital, St. Stephen, New Brunswick, Canada.

DIETITIAN—For 100-bed hospital; salary depends on experience and qualifications. For particulars apply, Superintendent, Soldiers' Memorial Hospital, Campbellton, New Brunswick, Canada.

DIETITIAN—190-bed state tuberculosis sanatorium; $275 per month; complete maintenance; supervision of 20 kitchen employees. Apply, Superintendent, State Sanatorium, Sanator, South Dakota.

DIETITIAN—A.D.A. member, for fully approved 110-bed hospital located 45 miles from Buffalo and Rochester; good pay, no week-ends, four weeks' vacation; retirement plan; excellent personnel; complete new building with model dietary department now under construction. Write fully to R. A. Anderson, Superintendent, Community Hospital, Warsaw, New York.

DIETITIAN—Qualified, for therapeutic diet department; wanted by September 1; 225-bed hospital in southwestern Illinois; salary $325 including meals and professional laundry; 40-hour week; sick leave; social security. MO 96, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIETITIAN—To head department; new 125-bed general hospital; completely equipped, ultra-modern diet kitchen; excellent salary and advancement opportunities; 40-hour week; social security; liberal paid vacations; sick leave; A.D.A. preferred. Apply, Personnel Director, St. Joseph Hospital, Aberdeen, Washington.

(Continued on page 194)

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POSITIONS OPEN

DIETITIAN—Assistant and therapeutic; immediate opening, 200-bed approved hospital in western suburb of Chicago. Apply, Dietitian, Memorial Hospital, Elmhurst, Illinois.

DIETITIAN—Fully qualified, with hospital experience, for 204-bed sanatorium; salary commensurate with ability. Apply, Superintendent, Essex County Sanatorium, Windsor, Ontario, Canada.

DIETITIAN—Registered; for 200-bed modern teaching hospital; 40-hour week; good salary. Apply, Box 840, Battle Creek, Michigan.

DIETITIANS—Therapeutic and administrative; Barnes Hospital, large teaching hospital; 3 units affiliated with Washington University School of Medicine; beginning salary $245 month; social security. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIRECTOR—Educational; degree required, experience preferred; accredited school of nursing connected with 300-bed, well equipped, general hospital; one class annually; sciences taught at nearby college; salary open, all cash; room available, if desired; liberal personnel policies; hospital located near New York, Philadelphia and the Atlantic coast. Apply, Director of Nursing, Mercer Hospital, Trenton, New Jersey.

DIRECTOR — Educational; for accredited school of nursing connected with 330-bed general hospital; 1 class admitted annually; plans for university association; salary open; 44-hour week, 8 holidays, 4 weeks vacation, 12 days sick leave. Apply, Director of Nursing, Perth Amboy General Hospital, Perth Amboy, New Jersey.

DIRECTOR OF NURSES—72-bed hospital expanding to 130 beds, located in progressive small community; 44-hour week; vacation, sick leave, social security; attractive apartment; salary open, depending on qualifications. Audrain Hospital, Mexico, Missouri.

DIRECTOR OF NURSES—For 100-bed general hospital with school of nursing, November 1; degree and experience in nursing education necessary; salary open; excellent personnel policies; hospital located in southwestern part of Virginia; ideal climate. Apply, Administrator, Pulaski Hospital, Pulaski, Virginia.

DIRECTOR—NURSING. To take charge of nursing home, attractively located, 24 beds; operated by The Benjamin Rose Institute in conjunction with the Benjamin Rose Hospital, affiliated with Western Reserve University Medical School and university hospitals; attractive newly remodeled apartment available, offering complete privacy; salary open. The Benjamin Rose Institute, 1000 Rose Building, Cleveland 15, Ohio.

(Continued on page 196)

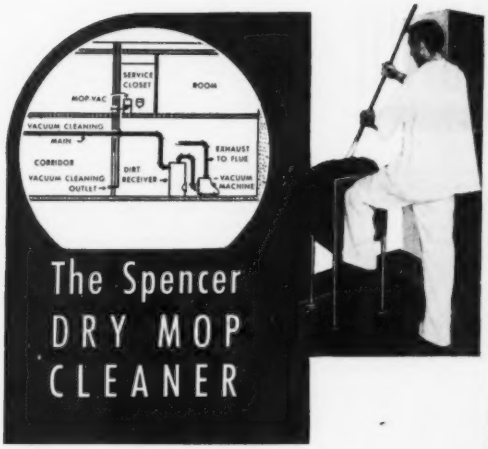
DIRECTOR OF NURSING—Assistant; 350-bed hospital; degree and experience desired; 40-hour week. Apply to: Director of Nursing, University of Pennsylvania Graduate Hospital, 1818 Lombard Street, Philadelphia 46, Pennsylvania.

INSTRUCTOR—Clinical; to teach orthopedics and the communicable diseases; salary for degree and experience $3804 to $4164; retirement program and social security; 441-bed hospital in a beautiful 40-acre park; liberal personnel policies. Apply, Director of Nurses, Reading Hospital, Reading, Pennsylvania.

INSTRUCTOR—Clinical; for medical and surgical nursing; B.S. in Nursing Education required. Apply, Director of Nursing, East Orange General Hospital, East Orange, New Jersey.

INSTRUCTOR—And supervisor, clinical; for active general hospital of 130 beds; new hospital to be completed December 1; attractive nurses' residence and surroundings; salary open and dependent upon preparation and experience. Apply, Director of Nursing, Columbia Memorial Hospital, Hudson, New York.

INSTRUCTOR—Nursing arts; for basic professional program in school of nursing affiliated with university offering B.S. Degree in Nursing; 300-bed hospital; school enrollment 200 students; degree necessary; starting salary open; position open immediately; good personnel policies. Apply, Director of Education, Arkansas Baptist Hospital, 13th and Wolfe Streets, Little Rock, Arkansas.



Hospitals equipped with Spencer Vacuum Cleaning will never have a dry mop cleaning problem. A Spencer Mop-Vac cabinet is located in a service closet on every floor. No extra steps—and all the dust goes down the vacuum system to the basement.

The Mop-Vac consists of a slotted plate mounted flush in the floor or on a box cabinet with a foot operated valve. Open the valve and air rushes through the slot. Pass the mop over the slot and the high velocity air agitates the strands, and removes the dust. Dust cloths are cleaned the same way.

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The simple attachment illustrated at the right may be inserted in the Spencer baseboard inlet valve. The Spencer floor valve may be connected to the pipe system under the floor, and a box type is available for attaching to the Spencer Portable Vacuum Cleaner. Ask for Bulletin No. 138-C on Spencer Mop-Vac and Bulletin No. 133 on Stationary Vacuum Cleaning Systems.

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Novaproofing is a term used to signify a coordinated science of protecting buildings from the weather; it crystallizes 20 years of research and tested methods. The records indicate that some one or more of the Novaproofing products and methods can correct almost any water condition—even after all other methods have failed.

The scientific aspects of Novaproofing are based upon a recognition of the strengths and weaknesses of concrete and mortar. They have *inherent* qualities which, properly leavened, mean increased protection from the weather, increased strength, increased service life. At the same time, the *workability* of the mixture must always be under full control. It can be varied in such a way as to produce concrete and mortar for each particular application in exactly the form it should have.

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NOVAMIX — For mass concrete, pargeting, stucco, slush coat, cement grout. Helps concrete and mortar to become stronger, more moisture-resistant—by controlling the rate of curing.

NOVACRETE—The "Micro-Milled" masonry paint with unexcelled water-resistance and long-wearing qualities. Preserves and beautifies stucco, cinder and concrete blocks and all masonry surfaces.

NOVAFILL—Acts as a water-repellent, sealing all hairline or seasoning cracks, solidifying the entire surface by sealing both the old porous surface and the new work at the same time.

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INSTRUCTOR—Nursing arts; for 192-bed hospital, 70 students; immediate opening; new educational department under construction; salary open. Apply to Director of Nursing, House of the Good Samaritan, Watertown, New York.

INSTRUCTOR—Of nurses; for training school of 35 students; attractive salary and maintenance provided; usual holidays and sick time allowed. Apply, Medical Superintendent, Victoria Hospital, Winnipeg, Manitoba, Canada.

INSTRUCTOR—Nursing arts; degree in nursing education required; experience desirable; salary open. Apply, Director of Nursing, Franklin Hospital, San Francisco 14, California.

INSTRUCTOR—Science; for 100-bed general hospital school of nursing; good working and living conditions; salary open, depending upon training and experience. Apply, Director of Nursing Science, Pulaski Hospital, Pulaski, Virginia.

INSTRUCTORS—Clinical; medical and surgical nursing; degree and experience required; salary dependent upon educational background and experience; 40-hour week. Apply, Director of Nursing, The Toledo Hospital, Toledo 6, Ohio.

INSTRUCTOR—Science; microbiology and assistant in chemistry or assistant in anatomy and physiology; six science instructors in department; salary for degree and experience $3804 to $4164; retirement program and social security; 441-bed hospital in beautiful 40-acre park; liberal personnel policies. Apply, Director of Nurses, Reading Hospital, Reading, Pennsylvania.

INSTRUCTOR—Science; degree required; one class per year; 40-hour week; 388-bed approved general hospital. Apply, Director of Nurses, Flushing Hospital, Flushing, New York.

INSTRUCTORS—Clinical; positions available: one for surgical teaching, one for specialties; B.S. Degree in Nursing Education; experience preferred; we are a 310-bed non-profit general hospital with 140-bed pavilion under construction; school has enrollment capacity of 200 students; excellent working conditions and paid benefits. Write, giving age, education, experience and salary desired: Personnel Manager, The Jewish Hospital Association, Cincinnati 29, Ohio.

INSTRUCTORS — Clinical; three; immediate openings: Pediatric, Obstetric, Medical and surgical nursing; 184-bed hospital; 75 student body; one class yearly; 44-hour week; average personnel policies; salaries open. Apply, Director of Nurses, Lewis-Gale Hospital, Roanoke, Virginia.

(Continued on page 198)

INSTRUCTORS—Instructor and Assistant instructors in nursing arts; positions open for fall term in a general hospital of 325 beds; 40-hour week. Apply, Director, School of Nursing, The Toledo Hospital, Toledo, Ohio.

INSTRUCTORS—One Science and one Nursing arts; for August 1; new hospital to be completed next fall; salaries open. Apply, Superintendent, Charlotte County Hospital, St. Stephen, New Brunswick, Canada.

LIBRARIAN — Medical record; department head to direct activities of record department in 350-bed hospital affiliated with Northwestern University; must be registered, thoroughly experienced in unit system and standard nomenclature; department well organized and work up-to-date; staff of ten; salary commensurate with experience. Apply, Personnel Director, Evanston Hospital, 2650 Ridge Avenue, Evanston, Illinois.

MATRON—For new, fully modern 36-bed hospital; attractive surroundings and ideal working conditions; separate nurses' residence; cumulative sick leave; 1 month holiday after 1 year service; duties to commence immediately. Apply, stating salary expected, qualifications and experience, Mrs. M. Hamilton, Secretary-Treasurer, District Memorial Hospital, Neepawa, Manitoba, Canada.

MEDICAL DIRECTOR—Vacancy in 575-bed teaching hospital; must be M.D. MO 97, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

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Dihydrostreptomycin Sulfate Solution (1 gram)

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POSITIONS OPEN

MEDICAL DIRECTOR—Assistant: 100- or 250-bed tuberculosis hospital; North American graduate; salary to $9500 commensurate with qualifications and experience; full maintenance. Apply, State Tuberculosis Hospital Commission, New State Office Building, Frankfort, Kentucky.

MEDICAL DIRECTOR—100-bed tuberculosis hospital; North American graduate; salary to $10,000 commensurate with qualifications and experience; full maintenance. Apply, State Tuberculosis Hospital Commission, New State Office Building, Franfort, Kentucky.

MISCELLANEOUS—Assistant director of nursing education; also, Medical nursing instructor; for a school of 105 to 120 students; college affiliation; four-year-old 254-bed general hospital; located 35 miles from Smoky National Park; opportunity for graduate study; Bachelor's Degree required; salary commensurate with qualifications and experience. Reply to Director of Nurses, East Tennessee Baptist Hospital, Knoxville, Tennessee.

MISCELLANEOUS—Science instructor for fall term; 120-bed hospital; 35 students; salary open; complete maintenance in comfortable suite; Operating room nurse and General staff nurses also. Apply, Director of Nurses, Jeffery Hale's Hospital, Quebec City, Quebec, Canada.

MISCELLANEOUS—(a) Director-instructor, school of practical nursing; also four Registered nurses; Ganado Mission, Ganado, Arizona. (b) Director of nurses; also Science teacher; Presbyterian Hospital, San Juan, Puerto Rico. (c) Nursing supervisor qualified to give anesthesia, Valley Hospital, Palmer, Alaska. (d) School nurse, Sheldon Jackson Junior College, Sitka, Alaska. Urgently needed; all candidates must be single, Protestant, in good health, and under fifty. Write, Department of Missionary Personnel, PRESBYTERIAN BOARD OF NATIONAL MISSIONS, 156 Fifth Avenue, New York 10, New York.

MISCELLANEOUS—General duty nurses, Supervisors, combined Laboratory and X-ray technician. Refer correspondence to, Myrtice P. Sheffield, R.N., Superintendent, Suwannee County Hospital, Live Oak, Florida.

MISCELLANEOUS—Superintendent of nurses and Assistant superintendent of nurses: state salary expected; Operating room supervisor: salary $220 gross; Science instructor: salary $220 gross; Arts instructor: $220 gross; General duty nurses: salary $180-195 gross depending on experience; 44-hour week; 2½ days holiday per month; half day on statutory holidays; 1½ days per month sick time cumulative to 30 days; charge of $30 per month for board and room; nurses working evening and night shifts to receive $5 per month over schedule. Apply to Mrs. M. Alexander, Acting Superintendent of Nurses, General Hospital, Medicine Hat, Alberta, Canada.

(Continued on page 200)

MISCELLANEOUS—Supervisor and Graduate nurse for 20-bed hospital; salary $250 per month, all meals and uniform laundry; wonderful climate, beautiful section of the country; near Yellowstone Park and Sun Valley. MO 95, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

NURSE—General duty; small growing hospital; good pay, part maintenance; paid vacations; pleasant working conditions. Apply, Supervisor of Nurses, Hi-Plains Hospital, Hale Center, Texas.

NURSE—General duty; for 50-bed modern sanatorium in northwestern Wyoming; salary $200 per month with maintenance. Apply, State Sanatorium, Basin, Wyoming.

NURSE—General floor supervisor for 34-bed hospital; salary open. Reed City Hospital, Reed City, Michigan.

NURSE—Head, for well equipped orthopedic unit in teaching hospital affiliated with Northwestern University; must have degree or postgraduate course; the hospital is near the lake and convenient to all types of cultural and recreational facilities; 40-hour week; 4 weeks vacation; paid sick leave; starting salary $300. Apply, Director of Nurses, Evanston Hospital, 2650 Ridge Avenue, Evanston, Illinois.

NURSE—Registered; for general duty; meals while on duty and laundry of uniforms. Apply, Business Manager, Lockney General Hospital, Lockney, Texas.

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POSITIONS OPEN

NURSE—Staff, obstetrical; 5 days, 40 hours, 3 to 11; initial salary $250; vacation with pay after first year; increases at 6, 12 and 24 months. Columbia Hospital, Astoria, Oregon.

NURSES—Attractive assignments in new community 93-bed general hospital; operating rooms, delivery rooms, general duty on pediatric, surgical, medical, obstetrical wards. Apply to Director of Nursing, Memorial Hospital, Post Office Box 942, Modesto, California.

NURSES—General duty; for 360-bed general hospital; starting salary $175 per month with maintenance; $200 per month with partial maintenance; rotating shifts; two weeks' vacation; 30 days' sick leave; 6 holidays yearly with pay; 44-hour week; college courses available through night classes at local university. Apply Director of Nursing, Greenville General Hospital, Greenville, South Carolina.

NURSES—General duty; immediate openings; salary $220 per month and complete maintenance; liberal sick leave policy, and two weeks paid vacation after one year. Contact Administrator, Big Spring Hospital Corporation, Big Spring, Texas.

NURSES—General duty; for nursing team in medical and surgical services; opportunity for promotion and for university courses. Apply to Director of Nursing Service, University of Virginia Hospital, Charlottesville, Virginia.

NURSES—Graduate; for new 50-bed general hospital in thriving village, Catskill Mountains, 8-hour day, six-day week, time-and-one-half for overtime after 40 hours, rotating shifts; average gross cash salary $200 to $210 month; full maintenance available for $10.50 week. Apply Superintendent Nurses, Margaretville Hospital, Margaretville, New York. Phone Margaretville 50.

NURSES—Operating room and obstetrical; California hospital on San Francisco Bay; forty minutes from that city; 5-day week; salary $250 per month if applicant has advanced preparation or experience; $10 additional for evening and night duty; maintenance available. Director of Nursing, Alameda Hospital, Alameda, California.

NURSES—Psychiatric; men and women; for general duty positions open in a psychiatric wing of a 750-bed hospital. Write, Director of Nursing, Buffalo General Hospital, 100 High Street, Buffalo, New York.

NURSES—Registered; Hermann Hospital in the Texas Medical Center offers you unlimited opportunities; positions with pleasant working conditions are available now. Write, Director of Nurses, Hermann Hospital, Houston, Texas.

NURSES—Staff and operating room; for 59-bed hospital; straight 8 hours, 6 days a week; rotating service; sickness allowance, two weeks paid vacation; close to Gulf of Mexico. Apply, Lee Memorial Hospital, Fort Myers, Florida.

(Continued on page 202)

NURSES—Registered; graduate experience in psychiatry desirable, but not essential; newly begun affiliation requires expansion of teaching unit and gives opportunity for rapid advancement; staff salary $225 to $260; social security; 40-hour week; vacation and sick leave; one meal and laundry. Apply, Director of Nursing Service, Utah State Hospital, Provo, Utah.

NURSES—Staff and Operating room; 5 days, 40 hours; 8 holidays and vacation with pay; initial salary $230 plus laundry; increases at 6, 12, 24 months; additional pay for evening and night assignments and for operating room calls. Apply, Director of Nursing, St. Luke's Hospital, New York 25, New York.

NURSES—General staff; 250-bed general hospital and 72-bed maternity hospital; starting salary $240; $5 per month tenure increase for each six months of service to a maximum of $270; two meals daily; social security, sick leave, prepaid medical and hospital care; $10 additional for afternoon and night duty; $15 additional for delivery room; $20 additional for surgery; up to three weeks' vacation at end of 5 years; 6 paid holidays; 8-hour day, 40-hour week. Apply to Director of Nurses, Sutter Hospital, Sacramento, California.

NURSES—Staff; for 8-hour, 5-day week, rotating service; salary $255 with full maintenance or $285 one meal and laundry; holidays, sick leave and paid vacation. Apply, Frances Halverstadt, R.N., Superintendent of Nurses, Municipal Contagious Disease Hospital, 3026 South California Avenue, Chicago, Illinois.

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NURSES—Staff; for a general hospital on medical, surgical and obstetric services; also vacancies on operating room staff; good personnel policies. Apply to Director of Nursing, Buffalo General Hospital, 100 High Street, Buffalo, New York.

NURSES—Staff; hospital for children with rheumatic fever; excellent salary, good working conditions, maintenance, vacation; near New York City. Apply, Executive Director, Irvington House, Irvington, New York.

NURSES—General staff; medical, surgical and obstetrical division; new 60-bed hospital in college town, 10,000 population; 41-hour week; 6 paid holidays, paid vacation; $225 monthly, one meal and laundry; position assigned on basis of preference. Write, Director of Nursing Service, Wood County Hospital, Bowling Green, Ohio.

NURSES—Staff; for a new 123-bed general hospital; ninety miles from Sun Valley; good basic salary and personnel policies. Apply, Director of Nurses, Magic Valley Memorial Hospital, Twin Falls, Idaho.

NURSES—Staff; for general hospital; 40-hour, 5-day week; $250 with laundry of uniforms; $10 additional for evening, night, maternity duty; increases yearly; must be eligible for registration in California; housing available. Write, Mercy Hospital, Sacramento, California.

NURSES—General staff; for new 18-bed hospital in small, friendly town; salary $250 per month for 40-hour week; eight consecutive hours of duty and rotating shifts; nine paid holidays; two weeks vacation after one year of employment; meals at cost at hospital. Send applications to Administrator, Pioneers Hospital, Meeker, Colorado.

NURSES—Suture, for operating room; for 369-bed teaching hospital located in a community 17 miles from New York City; 40-hour week; minimum salary $225 per month. Apply, Director of Nursing, New Rochelle Hospital, New Rochelle, New York.

PHYSICIAN—Resident; 100- or 250-bed tuberculosis hospital; salary to $9000 and complete maintenance. Apply, State Tuberculosis Hospital Commission, New State Office Building, Frankfort, Kentucky.

PHYSICIAN — Resident; for active thoracic surgery service; salary to $9000 commensurate with qualifications and experience; full maintenance; tuberculosis hospital. Apply, State Tuberculosis Hospital Commission, New State Office Building, Frankfort, Kentucky.

SUPERVISOR—Clinical teaching, communicable diseases, for nationally accredited school of nursing affiliated with Northwestern University; exceptionally well equipped polio unit; must have degree or postgraduate course; community offers outstanding cultural and recreational advantages; 40-hour week; 4 weeks vacation; paid sick leave; starting salary $300. Apply, Director of Nurses, Evanston Hospital, 2650 Ridge Avenue, Evanston, Illinois.

(Continued on page 204)

SUPERVISOR—Central supply; 400-bed hospital; experience in all phases of central supply duties and supervision; salary $245 per month with additional increments according to length of service. Contact Personnel Director, Iowa Methodist Hospital, Des Moines 14, Iowa.

SUPERVISOR—Obstetrical; 388-bed hospital, active obstetrical department; B.S. degree required; responsible for administration of division and instruction of student nurses. Apply, Director of Nursing, Flushing Hospital, Flushing, New York.

SUPERVISOR — Obstetrical and operating room; postgraduate work desired; new 60-bed hospital in college town, 10,000 population; $240 monthly, one meal and laundry; pay for call and overtime; 6 paid holidays, paid vacation. Write, Director of Nursing Service, Wood County Hospital, Bowling Green, Ohio.

SUPERVISOR—Operating room; large hospital, active service; position open October 1; mature experienced person; salary open, annual increments; vacation and sick time; 48-hour week, straight shift; travel expenses for personal interview. Apply, Superintendent of Nurses, Winnipeg General Hospital, Winnipeg, Manitoba, Canada.

SUPERVISOR—Operating room; for 100-bed general hospital, located in southwest Virginia; excellent working and living conditions; salary open. Apply, Superintendent of Nurses, Pulaski Hospital, Pulaski, Virginia.

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POSITIONS OPEN

SUPERVISOR—Operating room; small general hospital. Write, Harry Gerard, Superintendent, Trenton General Hospital, 140 North Clinton Avenue, Trenton, New Jersey.

SUPERVISOR—Pediatric; for 442-bed institution located in Delaware; student body of 165; applicant must have a degree in nursing education, or be working for a degree; salary depends upon qualifications of the applicant. Apply to Director, School of Nursing, Delaware Hospital, Wilmington, Delaware.

SUPERVISORS—Two assistant night supervisors capable of taking charge in delivery room; 44-hour week; gross salary, $210-265; may live in residence. For full particulars, apply, Superintendent of Nurses, General Hospital, Moose Jaw, Saskatchewan, Canada.

SUPERVISORS—Obstetrical supervisor for 70-bed unit, 35 mothers, 35 infants; and Medical-surgical supervisor for 54-bed unit; holidays, vacation and sick leave; 40-hour week, pay for overtime; good salary for qualified person; post-graduate work and experience required. Lutheran Hospital of Maryland, Baltimore 16, Maryland.

TECHNICIAN — Laboratory; non-registered; for approved general 200-bed hospital in Midwest; salary range from $214.50 to $240.50; nice working conditions. MO 92, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

TECHNICIAN — Laboratory; registered; approved hospital has an opening that pays from $266.50 to $318.50; city of 75,000; write for more information—let us tell you more about this opening. MO 93, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

TECHNICIAN—Laboratory; one with experience in supervision, in the training of those who will assist and in instructing students; this position is open and presents a real opportunity; general approved hospital, 200 beds; well equipped department; nice living quarters available nearby; salary range from $325 to $377. MO 94, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

OUR 55th YEAR

WOODWARD
Medical Personnel Bureau
FORMERLY AXNOE'S
3rd floor • 185 N. WABASH AVE.
CHICAGO • 1
• ANN WOODWARD • *Director*

If None of These Opportunities Meet Your Requirements, Let Us Prepare an Individual Survey for You. Please Ask for an Analysis Form. Strictly Confidential.

ADMINISTRATORS — (a) Medical; general, voluntary 150-bed hospital; residential town 25,000 near metropolis; east. (b) Medical; director and superintendent; modern, new general hospital; 125 beds; fine community 10,000; west. (c) Lay; 300-bed general, voluntary hospital nearing remodeling completion; open staff of about 50 doctors; excellent nursing school, 80 students; desirable residential town 25,000; southeast. (d) Lay; 300-bed hospital outside United States; duties include supervision fifteen infirmaries located various islands of the Pacific; requires outstanding administrator; now completing plans for much larger hospital; interested more in practical experience than formal academic training. (e) Lay; 350-bed general, voluntary hospital; large traumatic service; completely departmentalized; staff of 100 physicians; excellent nurses training school; city 125,000, east. (f) Lay; to replace present administrator resigning after long tenure; 200-bed general voluntary hospital; completing 75-bed addition; lovely college town; midwest. (g) Assistant; 500 beds; medical school affiliations; east.

(Continued on page 206)

WOODWARD—*Continued*

ADMINISTRATORS—NURSES. (a) Assistant; 250-bed general voluntary hospital; building 125-bed obstetrical addition; university medical center city 2,000,000. (b) New and modern 60-bed hospital; excellent starting salary; residential town; west. (c) 50-bed modern, association hospital; $450; town not too far from St. Louis. (d) Preferably with some surgery, laboratory and x-ray experience; able handle records and personnel; fine 10-bed hospital; $350; west.

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POSITIONS OPEN

WOODWARD—*Continued*

ADMINISTRATIVE STAFF APPOINTMENTS—(a) Business manager; group 4 distinguished doctors; near Yellowstone Park; (b) Executive secretary; one well experienced in campaign programs and public relations; important medical association; west coast. (c) Personnel manager; new Hill-Burton 200-bed hospital; fine residential town; south. (d) To supervise all accounting and financial affairs of 175-bed general voluntary hospital; requires major in accounting; lovely town 20,000; New York. (e) Business managers; for 3 state institutions; work under medical directors; some administrative and personnel work; $6000 plus full maintenance pending new budget arrangement; southwest. (f) Personnel director; plan and administer personnel program for 240-bed California hospital; city 100,000 near university. (g) Clinic director; independent outpatient unit of large general hospital; about $6500; city 2,000,000.

ANESTHETISTS—(a) Clinic; 20-man group; $6000; midwest. (b) New air-conditioned hospital; owned by leading American company; foreign appointment; tropical country; mild climate; 1- or 2-year contract; transportation; $5000 plus bonus.

WOODWARD—*Continued*

COLLEGE AND STUDENT HEALTH—(a) Public school nurse; experienced; five-day week; $3600 plus car allowance; lovely resort community; southwest. (b) Student health; co-educational college; some teaching and public health training; to $3600; near Chicago.

DIETITIANS—(a) Chief; large teaching hospital; complete charge dietary department; to $4800; college city; west coast. (b) Chief; well staffed department; large general hospital; $6000; desirable college city; east coast.

DIRECTORS OF NURSES—(a) General hospital, 250 beds; excellent medical staff; large student nurse enrollment; $6000. (b) General hospital, 300 beds; $6000; attractive community near New York City; pleasant living. (c) New 200-bed children's hospital now under construction; requires one well qualified in pediatrics; much sought after Mexican Gulf location; about $6000.

EXECUTIVE HOUSEKEEPERS—(a) Hospital-clinic group with major expansion program; three assistants; staff of seventy; attractive southern locality. (b) General hospital, 600 beds; two assistants; staff of sixty; complete charge, planning, supervision and training; recommended.

FACULTY APPOINTMENTS—(a) Educational director; important west-coast college of nursing. (b) Assistant director, college of nursing; some teaching if desired; minimum $5000. (c) Clinic instructor; 35-bed, pediatric

(Continued on page 208)

WOODWARD—*Continued*

unit, 300-bed university teaching hospital; $4000; Great Lakes region. (d) Nursing arts instructor; opportunity head department of nursing in collegiate program; $6000, maintenance.

OCCUPATIONAL THERAPIST—Twelve man group-clinic, well established; 5½ day week; about $5000; desirable college city; south.

PHARMACIST—New air-conditioned hospital; owned by leading American company, foreign appointment; 1- or 2-year contract; work with Americans; tropical country; $6000; bonus; transportation for self and family.

PHYSIOTHERAPISTS—(a) For office of distinguished physician; will meet financial requirements well qualified person; town, 49,000; noted resort region; southwest. (b) Complete charge new physiotherapy department in 75-bed university infirmary; also teach course basic physiotherapy principles to pre-physiotherapy students; about $4200; attractive university community; pleasant living.

PHYSIOLOGIST—Large, approved, mental hospital; minimum $5000; maintenance available; midwest.

PUBLIC HEALTH NURSES—(a) Co-ordinator, school of nursing; 300-bed teaching hospital; well equipped classrooms and library; university affiliation. (b) Department, Public Health; attractive, desirable Lake Michigan resort community; car furnished; substantial salary.

classified advertising

POSITIONS OPEN

WOODWARD—*Continued*

SOCIAL SERVICE—Medical; to organize department of new general hospital, 150 beds; $4000; attractive locality; south central.

SUPERVISORS—(a) Operating room; excellent general hospital with huge expansion program; $3600 plus full maintenance; New York residential suburb. (b) Obstetrical; complete charge obstetrical unit; formal planning and instruction of clinical student teaching; degree required; substantial salary. (c) Pediatric; responsible student ward conferences; follow up clinical lectures; 40 hours; $3700. (d) Psychiatric; 43-bed unit; large general teaching hospital; minimum $3600; South Atlantic coast.

INTERSTATE HOSPITAL AND PERSONNEL BUREAU
Miss Elsie Day, Director
332 Bulkley Building
Cleveland, Ohio

ANESTHETISTS — (a) Southwest; modern hospital; 100 beds; $450, maintenance. (b) East; $400.

INTERSTATE—*Continued*

DIRECTORS, NURSING SERVICE—(a) 100-250 bed tuberculosis sanatoriums; teaching centers; midwestern and southern states; to $6000. (b) 400-bed hospital, midwest. (c) 100-bed new hospital; college town; central states. (d) 70-bed new hospital; east.

NURSE SUPERINTENDENTS — (a) 60-bed hospital, northwest; graduate staff. (b) 25-bed hospital, southwest; resort city. (c) 60-bed hospital, Pennsylvania. (d) New 35-bed hospital, Ohio; $400, maintenance.

OFFICE MANAGERS—(a) 300-bed hospital, near Detroit. (b) 100-bed hospital, eastern Ohio.

ADMINISTRATORS—(a) 125-bed hospital, Pennsylvania. (b) 100-bed hospital, M.N., south; salary open. (c) 90-bed hospital, college town, midwest. (d) Small hospitals, under construction; Ohio, California, South.

RECORD LIBRARIANS—(a) 300-bed eastern hospital; large outpatient clinic; $375. (b) 125-bed Ohio hospital; $325. (c) Texas; $300.

X-RAY TECHNICIANS—(a) Male and female, $300-$375. (b) Laboratory; $275-$350; east, midwest and south.

DIETITIANS—(a) Chief; 300-bed teaching hospital; east. (b) 250-bed hospital; midwest; $400. (c) Therapeutic; east, midwest, south.

(Continued on page 210)

INTERSTATE—*Continued*

EXECUTIVE HOUSEKEEPERS—(a) 225-bed hospital, crippled children; good opportunity; east. (b) 300-bed hospital, Baltimore area. (c) 300-bed Sisters' hospitals, midwest; east; south. (d) Southwest.

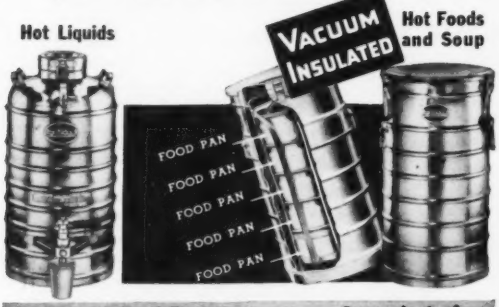
SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

DIRECTORS OF NURSES—(a) East; 230-bed hospital in city of 70,000; 5 years experience required; $6000. (b) 100-bed hospital in beautiful colonial town of 7000; $5000. (c) Middle west; 75-bed hospital about 3 hours' ride from Chicago; $5400, maintenance. (d) South; 250-bed hospital in large southern city; nursing section well organized with well qualified supervisors; $5400, maintenance.

DIETITIANS—(a) Chief; east; 225-bed hospital; ideally located in New England city of 35,000; duties all administrative; $5000, maintenance. (b) Chief; middle west; 200-bed general hospital in city of 75,000; experienced, cooperative staff; $4800 to start. (c) Therapeutic; middle west; 195-bed hospital; $3900. (d) Chief; southwest; direct all activities of department; 3 well qualified assistants; excellent salary for qualified person.

Booth 801, A.H.A. Convention, Philadelphia.

Better Hot Foods for Institutions



AerVoiD *Vacuum Insulated*
HOT FOOD, SOUP AND COFFEE CARRIERS

Just transfer hot foods, soups, coffee from cooking kettles and coffee urns into AerVoiD food and liquid carriers and the high VACUUM INSULATION of AerVoiDs will keep them hot for hours . . . transportable indoors or outdoors for servicing from a central kitchen. What a low-cost way to keep foods hot without continuous application of heat! Thousands in daily service amongst institutions, hospitals, industrial plants, schools, caterers and large Government and commercial feeding activities.

Write for Catalog Circular MH 12

VACUUM CAN COMPANY
19 SOUTH HOYNE AVENUE, CHICAGO 12, ILLINOIS

"WALL-SAVER" Chairs

- *PREVENT DAMAGE TO WALLS*
- *REDUCE CHAIR MAINTENANCE*

The back legs of a "Wall-Saver" chair are flared out so that the chair cannot be tipped backwards. No rubber leg bumpers are needed—the bottoms of the legs abut the baseboard while there is still ample clearance between the back of the chair and the wall. This unusual design eliminates the strain to which an ordinary chair is subjected when the sitter "rocks" in it. It also prevents damage to both chair and wall caused by "resting" the back of the chair against the wall. As a result, "Wall-Saver" chairs can pay for themselves through savings.

Right: No. 1082 "Wall-Saver" Easy Chair.
Left: No. 1089½ "Wall-Saver" Straight Chair. (Also available with saddle wood seat, or with upholstered seat and back.)

Write for Bulletin 1005-A

"WALL-SAVER" Advantages
1. CANNOT BE TIPPED BACKWARDS
2. CHAIR CAN'T DAMAGE SIDE OR BACK WALL

EICHENLAUBS
For Better Furniture
3001 BUTLER ST., PITTSBURGH 1, PA.
ESTABLISHED 1873

YOU CAN'T AVOID

DIRTY FLOORS

Sure as you have *floors*, you can expect to clean DIRTY FLOORS—every day, every week—year after year! You just *can't* avoid DIRTY FLOORS!

BUT YOU CAN

CLEAN ANY FLOOR

EASIER
FASTER
AT LESS COST

...WITH WHITE

Floor Cleaning Equipment

Here's a round bucket outfit that can't be beat for efficiency and economy! Foot operated wringer for greater pressure and easy mop handling. See the complete White line at your dealer's . . . Write for Catalog No. 150.

WHITEY MOPZUM SAYS: *It's RIGHT . . if it's*

WHITE MOP WRINGER CO.
9 Mohawk Street
Fultonville, N.Y.

WHITE

A COMPLETE LINE OF FLOOR CLEANING EQUIPMENT

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POSITIONS OPEN

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

PALMOLIVE BUILDING CHICAGO

ADMINISTRATORS—(a) Lay or medical; 400-bed general hospital; expansion program; college town, 100,000, east; $15,000-$18,000. (b) Medical or lay; fairly large general hospital; California. (c) Medical director and assistant superintendent; 700-bed teaching hospital; large city, important medical center. (d) General hospital, 300 beds, currently in planning stage; will consider consulting or full-time basis; midwest. (e) Lay; general hospital, 200 beds; associated with medical center diagnostic unit; construction about to commence; building experience desirable; large city, university center, midwest. (f) New hospital, 150 beds; college town, south. (g) Lay; to succeed administrator retiring after long tenure; college town, 200,000, east; minimum $15,000. (h) Assistant; 300-bed general hospital; building program will expand facilities to 425; east. (i) Clinic manager; 14-man group; west. (j) Administrator with research interest and also public relations director; interesting opportunity, professional organization. MH8-1

MEDICAL BUREAU—*Continued*

ADMINISTRATORS—NURSES. (a) New institution, 200 beds, under construction; east. (b) General, 160 beds; midwest metropolis. (c) New hospital, 100 beds, general; fashionable resort city, south. (d) Assistant; 300-bed hospital; midwest. (e) New hospital, small size, well endowed; New England. MH8-2

ANESTHETISTS—(a) Hospital and clinic of outstanding specialists; $450-$540; Pacific Coast. (b) New general hospital; foreign operations, leading industrial company; $7200. (c) Association with two medical anesthesiologists; university center, east. MH8-3

CLINIC, COLLEGE, STUDENT HEALTH—(a) Assistant director in charge of outpatient nursing service qualified to serve as director of health and welfare; one of country's largest teaching institutions. (b) Supervisor; health department specializing in treatment of problem children; training provided as mental hygienist; minimum $5000; midwest. (c) Director, health program, liberal arts college; nine-month year; minimum $4000. MH8-4

DIETITIANS—(a) Chief; 350-bed teaching hospital; modern, well equipped department; university medical center; south. (b) Chief; voluntary general hospital, 250 beds; expansion program; attractive location, California. (c) Assistant chief; 150-bed hospital, college town, near New York City; minimum $300, maintenance. (d) Assistant administrative and, also, therapeutic dietitians; fairly large hospital; southern California. MH8-5

(Continued on page 212)

MEDICAL BUREAU—*Continued*

DIRECTORS OF NURSES—(a) Voluntary general hospital, 450 beds; college affiliations; duties with school only; large city, university medical center, west. (b) Administrative assistant; one of country's largest schools of nursing; faculty appointment; assistant professor. (c) Pediatric hospital now under construction; completion soon; well endowed; coast city, southwest. (d) Director, new cancer hospital, unit, university group; should know atomic energy nursing, qualified to train nurses, technique of using radioactive isotopes; Master's advantageous. (e) Teaching hospital, 600 beds; university center, south; $7200. (f) Associate director, nursing service; large teaching hospital; university medical center; east. (g) Nursing service only; general hospital; average census, 290; expansion program; California; opportunity continuing studies. MH8-6

EXECUTIVE HOUSEKEEPERS—(a) General 350-bed hospital; large city, university center, west. (b) Voluntary general hospital, 200 beds; residential town; New England. MH8-7

EXECUTIVE PERSONNEL—(a) Food service manager, qualified take over administrative aspects, dietary service; fairly large general hospital; Chicago area. (b) Personnel director; 250-bed hospital; vicinity New York City. (c) Hospital accountant; 300-bed hospital; midwest. (d) Maintenance engineer, qualified supervise staff of 50; large general hospital; metropolitan area, midwest. MH8-8

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POSITIONS OPEN

MEDICAL BUREAU—*Continued*

FACULTY POSTS—(a) Educational director and clinical instructors in medicine, surgery, pediatrics; collegiate school; university city, Pacific Northwest. (b) Assistant professor, public health nursing and, assistant professor psychiatric nursing; university appointments; former position requires considerable travel, ability develop 4-year collegiate program; salaries, $5000-$6000. (c) Science instructor; small school; college town, New England; $4000, complete maintenance including apartment. (d) Nursing arts instructor; duties; teaching at liberal arts college, school, 300-bed general hospital; university town; minimum $500. MH8-9

MEDICAL RECORD LIBRARIANS — (a) Chief; voluntary, general hospital, fairly large size, fully approved; California. (b) Chief; man preferred, woman eligible; 600-bed hospital; eastern metropolis. (c) Chief; large general hospital affiliated medical school; department staff of fifty; south. (d) Chief; one of leading hospitals, Chicago area. MH8-10

PHARMACISTS—(a) Foreign operations, large industrial company; around $8600. (b) Chief; new 400-bed general hospital; university town, south. MH8-11

MEDICAL BUREAU—*Continued*

SUPERVISORS—(a) Operating room; new 300-bed hospital affiliated with diagnostic clinic; residential town near university center, east. (b) Pediatric; new hospital; completion soon; fairly large; general; California. (c) Obstetrics; new 225-bed hospital; fully air-conditioned; college town, south. (d) Orthopedic; well staffed department; southern California. (e) Two surgery supervisors; teaching hospital operated under American auspices in Near East. (f) Psychiatric; new 22-bed department; important hospital; Wisconsin. (g) Central supply; new hospital, 250 beds; university city, west. (h) Surgical; new hospital; Alaska. MH8-12

MEDICAL PERSONNEL EXCHANGE
Nellie A. Gealt, R.N., Director
4707 Springfield Avenue
Philadelphia 43, Pennsylvania

DIRECTOR OF NURSES—250-bed hospital; $4800 plus maintenance, including an apartment.

OBSTETRICAL SUPERVISOR—Now or September 1; well equipped department, general hospital; 40-hour week; liberal salary and personnel policies.

OPERATING ROOM SUPERVISOR—New 150-bed hospital; graduate staff; university town; $300 plus excellent maintenance.

(Continued on page 214)

MEDICAL PERSONNEL EXCHANGE—*Continued*

MAINTENANCE ENGINEER—900-bed medical college hospital; requires top-level person.

No charge for registration

PLACEMENT BUREAUS

ZINSER PERSONNEL SERVICE

Anne V. Zinser, Director

Suite 1004—79 West Monroe Street

Chicago 2, Illinois

We have many good openings for Directors of Nurses, Instructors, Supervisors, Dietitians, Medical Technicians, Record Librarians and Staff Nurses. If you are looking for a position, please write us.

HOSPITAL PERSONNEL BUREAU

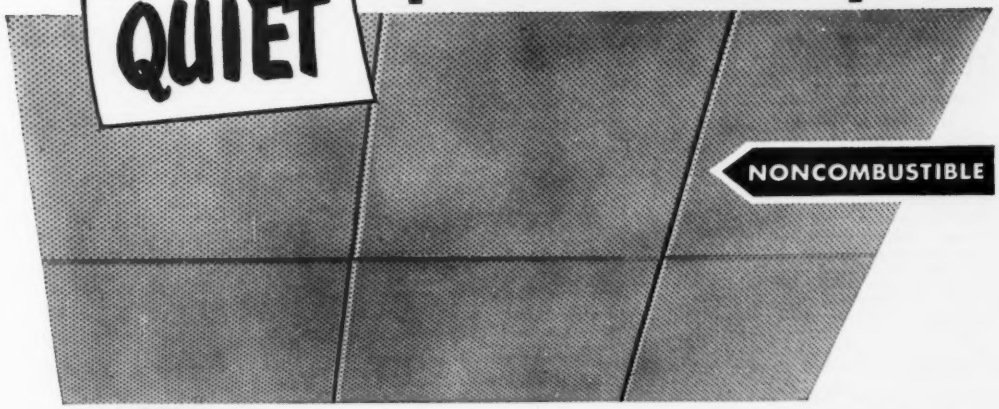
Charles J. Cotter, Director

Professional Arts Building

Hagerstown, Maryland

Positions available for Nurse Anesthetists (AANA), 40-hour week, top salary and overtime; also Dietitians (ADA). No registration or employment fee. Send complete resumé and 5 small photos; date available.

QUIET speeds recovery



Sanacoustic* Ceilings provide restful, strength-building quiet so necessary to patients' progress

TODAY, with "rest and quiet" playing an ever-increasing therapeutic role, hospitals do everything possible to eliminate noise.

By having Johns-Manville install Sanacoustic Ceilings, you provide quiet, and assure speedier recovery of the patient.

Sanacoustic Ceilings are not only the most efficient available, but they are *noncombustible*. They consist of perforated *metal panels* backed up with a fireproof, sound-absorbing element. Can be painted and repainted without loss of acoustical qualities. *Baked-enamel finish* makes them easy to keep clean and sanitary. Reception rooms and cafeterias, corridors and lobbies, nurseries and wards are among the "noise centers" especially in need of noise-quieting Sanacoustic.

For hospital areas subject to continuous and excessive moisture, you can choose our perforated Transite* *Asbestos* Panels.

Other J-M Acoustical Ceilings used in hospitals are Fibretone*, a drilled fibreboard for the most modest budget, that can be specified "with flame-resistant finish"; and Permacoustic*, a textured, noncombustible tile with great architectural appeal. For free book on Sound Control or an estimate, write Johns-Manville, Box 158, New York 16, N. Y.

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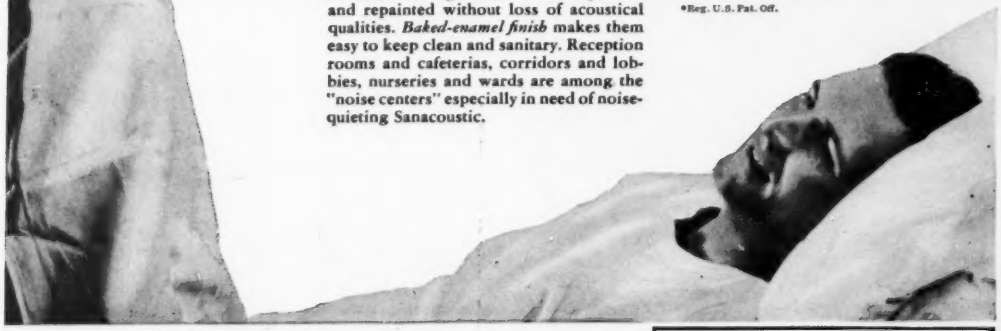

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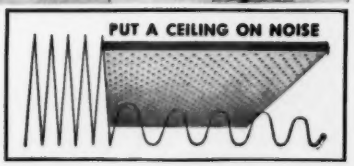

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PROFESSIONAL COUNSELING & PLACEMENT SERVICE

Non-fee charging Service for Nurses and Employers of Nurses.

Complete professional credentials of more than 40,000 nurses on file in 30 state nurses' associations and the national ANA office.

Consult your state nurses' association or the ANA PC&PS branch office, 8 South Michigan Avenue, Chicago 3, Illinois (Tel. STate 2-8883).

BUSINESS AND MEDICAL REGISTRY
(agency)
Elsie Miller, Director
610 South Broadway, Room 1105
Los Angeles 14, California

Opportunities for Administrators, Directors of Nurses, Instructors, Supervisors, Staff Nurses, Record Librarians, Dietitians, Technicians. West Coast hospitals operate on a 40-hour week.

FRANCES SHORTT MEDICAL AGENCY
SPECIALISTS in the Placement of Competent Medical and Social Service Personnel.
FRANCES SHORTT, R.N., Director
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BROWN'S MEDICAL BUREAU (Agency)
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If you are seeking a position or personnel—please write. Gladys Brown, Owner-Director. We Do Not Charge a Registration Fee.

MARY A. JOHNSON ASSOCIATES
11 West 42 Street New York 36, N.Y.

Mary A. Johnson wishes to announce the opening of her New York offices for the Placement of Hospital and Medical Personnel.

A cordial invitation is hereby extended to trustees and administrators to use the services of this agency when seeking qualified employees.

Applicants for hospital, medical group and allied fields are urged to inquire. No fee for registration.

See us at the convention—Booth 1015.

(Continued on page 216)

SOUTHERN CALIFORNIA MEDICAL AGENCY
610 South Broadway
Los Angeles 14, California
Telephone Madison 9-3529

We invite inquiries from employers desiring personnel and from applicants seeking positions.

MISCELLANEOUS

HENRY G. FARISH, M.D.
MEDICAL AUDITS FOR HOSPITALS
Sunbury, Pa. R.D. No. 2

HOSPITAL FOR RENT
FULLY EQUIPPED HOSPITAL FOR LEASE

—Comprising 12 beds, x-ray, operating room and laboratory facilities; ready-made practice serving population over 10,000; in central New Mexico; general practitioner preferred; lessee must meet AMA standards and possess qualifications for medical license to practice in New Mexico. Direct inquiry to: New Mexico Institute of Mining and Technology, Socorro, New Mexico.

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MISCELLANEOUS

SALES MANAGER
EXTRAORDINARY OPPORTUNITY

Well known live wire uniform and hospital garment manufacturer desires experienced modern minded sales manager. New York City firm doing three-quarters of a million dollar business regionally selling hospitals, hotels, restaurants, government agencies, east of the Mississippi, wishes to extend to national distribution. Wonderful chance for young-thinking sales minded executive. Big opportunity for business growth. Salary commensurate with experience and ability, with increases in proportion to increased business. Give complete details. All replies considered confidential. MO 88, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SALESMAN WANTED

to sell our MICROFILMING SERVICE. We specialize in hospital case-history microfilming at lowest prices. Our service is a MUST for overcrowded record rooms. Please write fully of yourself. The Check-Guard System, 2530 N. Front Street, Philadelphia, Pennsylvania.

FOR SALE

New and used hospital equipment bought and sold. Large stock on hand for the physician, hospital and laboratory. Write for what you want or have for sale.

HARRY D. WELLS
400 East 59th Street, New York City

EQUIPMENT FOR SALE

1 Aloe White Enamel OB table, fully equipped with hydraulic base
1 Utility table on wheels—2 shelves
1 Examining table—white enamel
1 Westinghouse Offset Surgical Light
1 Surgical Dome Light—single lamp
1 Castle light fixture—stationary—30" diameter

This equipment is of varying ages; however, all is usable and has just recently been retired from service. Will consider best offer. For particulars, call or write Mr. William MacDonald, Chief Engineer, Memorial Hospital, Elmhurst, Illinois.

(Continued on page 218)

NURSING AND MEDICINE

We have in stock every nursing or medical book published. Lowest prices with unexcelled service. Write Chicago Medical Book Company, Jackson and Honore Streets, Chicago 12, Illinois.

SCHOOLS—SPECIAL INSTRUCTION

THE COLLEGE OF NURSING
STATE UNIVERSITY OF IOWA
offers a program in
PSYCHIATRIC NURSING
leading to a Bachelor of Science Degree.

This program is designed to prepare graduate nurses to work therapeutically with emotionally disturbed people.

LENGTH OF THE PROGRAM will be determined on an individual basis. Theory and practice in psychiatric nursing will extend over a period of two semesters.

STIPENDS for some students will be made available under the Mental Health Act.

APPLICATIONS will be accepted for a short time only.

For further information write to:
Myrtle E. Kitchell, Dean
College of Nursing, State University of Iowa
Iowa City, Iowa.

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SCHOOLS—SPECIAL INSTRUCTION

THREE MONTH POSTGRADUATE COURSE IN CEREBRAL PALSY (limited at this time to qualified physicians, physical and occupational therapists). Dates: September 22-December 12, 1952.

Sponsored by THE COORDINATING COUNCIL FOR CEREBRAL PALSY IN NEW YORK CITY, INC., in cooperation with COLLEGE OF PHYSICIANS AND SURGEONS, COLUMBIA UNIVERSITY, and the various diagnostic and treatment centers of Greater New York.

A professional statement of completion will be granted by Columbia University upon satisfactory completion of the three months course.

A list of available sources for study scholarships which include living stipend will be sent upon request.

For full information, write to Miss Marguerite Abbott, Executive Director, Coordinating Council for Cerebral Palsy, 270 Park Avenue, New York 17, New York.

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and a stipend of $60 a month provided. For full information, apply to the Director of Nurses, Providence Lying-in Hospital, Providence 8, Rhode Island.

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Mo.

WOMAN'S HOSPITAL, Detroit, Michigan, offers a four months' clinical course in Obstetric Nursing to qualified professional nurses. Full maintenance and a monthly stipend of $100 allowed. The next class enters September 8, 1952. For further information apply, Director of Nurses, 432 East Hancock Avenue, Detroit 1, Michigan.

GRADUATE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA offers a four months' course in operating room technic and management to registered graduates of accredited schools of nursing. Tuition fee $20. Full maintenance and $30 monthly cash allowance given. Apply to Director of Nursing, 1818 Lombard Street, Philadelphia 46, Pennsylvania.

THE CHICAGO MEDICAL SOCIETY announces two postgraduate courses for 1952: Cardiovascular and Renal Diseases, September 29-October 3; Diseases of the Gastrointestinal Tract, Liver and Pancreas, October 6-10. Registration limited to 100. Tuition, $75 each course. For further information, write Committee on Postgraduate Medical Education, Chicago Medical Society, 86 East Randolph Street, Chicago 1, Illinois.

The MARGARET HAGUE MATERNITY HOSPITAL. The largest hospital in the country offers the following to registered, professional nurses of accredited schools:

Four Months' Course:

Included are obstetric lectures, nursing classes, techniques, laboratory science, nutrition, mothers' health and socio-economic aspects. Supervised experience is given in antepartal, intrapartal, postpartal and newborn infant care with a minimum of twenty-five hours of clinical instruction. Students may elect one month's experience in premature nursery, formula room, isolation, antepartal or clinic and field service.

Six Months' Course:

Following the above program, a two months' course is offered to students who have demonstrated potentialities for head nurse responsibilities. It includes instruction in principles and methods used in clinical teaching program and ward management. Students plan and conduct their program of clinical instruction with the head nurse and serve as assistants. They are directed and supervised by the instructor of the course.

Classes admitted every other month beginning February. Maintenance and stipend of $75.00 per month granted. Write for catalogue. Address Rose A. Coyle, R.N., Director of Nurses, 88 Clifton Place, Jersey City 4, New Jersey.

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Here's the last word in low-cost, space-saving, along-the-wall heating. Dunham's new Fin-Vector Radiation fits in functionally almost anywhere . . . in any type of building . . . at any height along outside walls.

Light in weight . . . but long on performance . . . Fin-Vector goes up fast, distributes heat evenly in long runs, looks like new . . . works like new . . . even after years of hard knocks.

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Send For Free Literature. Data Sheets 1256-61 fully describe and illustrate Fin-Vector features, capacities and types. Please write for your free copies to Dept. 19, C. A. Dunham Company, 400 W. Madison St., Chicago 6, Illinois.

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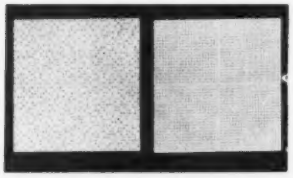
What's New for Hospitals

AUGUST 1952 Edited by BESSIE COVERT

TO HELP YOU get information quickly on new products described in this section, we have provided the convenient Readers' Service Form on page 232. Check the numbers of interest to you and mail the coupon to the address given on the form. If you wish other product information, just list the items and we shall make every effort to supply it.

Random Pattern Acoustical Tile



Containing all of the functional characteristics of Acousti-Celotex Perforated Tile, the new Random Pattern sound-absorbing tile has scatter perforations of varied sizes which blend into an over-all pattern of distinction. It provides a refreshing departure from conventional perforations and is standard in sizes and application.

Random Pattern tile has the new Celotex No. 6 Finish, tightly bonded to the surface of the tile. This highly light-reflective linen-textured surface is tough and washable, and may be repainted repeatedly without impairing sound absorptive capacity.

The new Random Pattern tile is also available with the Duo-Tex flame-retarding oil base painted finish which is also washable and meets all requirements of Federal Specifications for Slow Burning Classification. **The Celotex Corporation, Dept. MH, 120 S. La Salle St., Chicago 3. (Key No. 175)**

Elastic Bandage

The new B-D Asepto Rubber-Elastic Bandage is designed specifically to meet the requirements for a stronger, more durable product. It has a balanced weave—balanced porportions of rubber and cotton to give easy stretch and firm support, combined in a distinctive weave which provides greater strength and durability without increasing the weight or bulk of the bandage.

Because of the weave the new Asepto heavy duty bandage is able to stand repeated stretching with no filler material on release, and is capable of being washed under hospital conditions without becoming rough in appearance. It comes in sun tan color and is available in widths of 2, 2½, 3, 4, and 6 inches. **Becton, Dickinson & Co., Dept. MH, Rutherford, N. J. (Key No. 176)**

Glass Sterilizer Controls

A sample package containing five of the new and improved Propper glass sterilizer control tubes is now available to hospital personnel. The improved tubes are made from reannealed glass, selected for its uniformity. Each tube contains a hermetically sealed fusible tablet manufactured under strict control conditions for uniform performance. Each tube is guaranteed by the manufacturer to indicate the correct sterilization temperature. The new tubes are packaged in boxes especially designed and constructed to prevent the tubes spilling and to protect them from breakage. **Propper Mfg. Co., Dept. MH, 10-34 44th Drive, Long Island City 1, N. Y. (Key No. 177)**

"No-Tie" Patient's Gown

The new "No-Tie" Patient's Gown is designed to eliminate the second tape. It is constructed for comfort and convenience with a patented X-back which does away with knots and buttons that frequently cause discomfort to the patient. The gown is easily fastened or unfastened at the neckline without inconvenience to patient or nurse and the design of the gown eliminates the need for any additional fasteners. **Whitehouse Mfg. Co., Dept. MH, 361 W. Chestnut St., Chicago 10. (Key No. 178)**

"Beaker Bouncer"

A resilient mat for use in the bottom of sinks in the laboratory and pharmacy to help prevent breakage of glassware has been introduced as the "Beaker Bouncer." It is made of Akrolite, a chemically resistant material, on a firm steel mesh base. The mats are guaranteed by the company not to crack or harden, even with constant use. They are available in eight stock sizes, ranging from 12 by 8 inches to 30 by 15 inches, and in special sizes. **Meinecke & Co., Inc., Dept. MH, 225 Varick St., New York 14. (Key No. 179)**

Steraject Syringe

Especially designed to permit the administration of a wider variety of antibiotic solutions in disposable cartridges, the Steraject disposable cartridge syringe holds two sizes of cartridges. The syringe will hold a cartridge containing 1,000,000 units of procaine penicillin G aqueous suspension or a Combiotic aqueous suspension cartridge containing 400,000 units of penicillin and 0.5 gm. of dihydrostreptomycin. The large size cartridge and the formulations make both of these preparations readily syringeable. In the small sized cartridge 300,000 units of penicillin G procaine in aqueous suspension and 300,000 units of penicillin G procaine in oil with aluminum monostearate will be available.

The Steraject eliminates the need for sterilizing the hypodermic needle before administration since a sterile needle wrapped in foil comes with each cartridge. Hospitals using their own needles can obtain packages of 100 cartridges together with four needle adapters. Time is saved for personnel since antibiotic solutions and suspension come ready prepared in the cartridges, waste of antibiotic in multiple dose vials is eliminated

and storage and inventory accountability are simplified. **Chas. Pfizer & Co., Inc., Dept. MH, 630 Flushing Ave., Brooklyn 6, N. Y. (Key No. 180)**

(Continued on page 222)

What's New . . .

Inductotherm

The Model F Inductotherm is a new diathermy unit with output increased from 50 to 75 per cent. An electrosurgical unit is provided as an integral part of the new model. It is designed for use wherever the known benefits of heat are required for therapy. It is possible to generate a controlled heat deep within the body tissues without contact with the Inductotherm. Three types of eletrodes can be used with the Model F—cable, contour and air-spaced. The frequency output of the new model tends to limit the heating effect to the deep, vascular tissues without excessively heating the surface tissues. **General Electric Co., X-Ray Dept., Dept. MH, 4855 Electric Ave., Milwaukee 14, Wis. (Key No. 181)**

Film-Free Glass Suds

Fame is a new long-lasting suds for the hand washing of dishes, glasses, silver, pots and pans. It is soothing to the skin, has fast washing action and drains from glasses with amazing speed, leaving film-free surfaces. Fame is light blue in color and contains one of the newly perfected Wyandotte Pluronics. It is also inhibited against darkening aluminum in normal use solutions. **Wyandotte Chemicals Corp., Dept. MH, Wyandotte, Mich. (Key No. 182)**

Syracuse China Designs

Two new designs in Syracuse China are being introduced. The patterns are both on the Winthrop shape and will be additions to the firm's Hospitality Group of stock patterns.

Dogwood, one of the new stock patterns for the institutional field, features a rim motif. Three sprays, each containing three dogwood blossoms in natural tones on their own branches, decorate the plate rim. Sandalwood, the other new shadowtone pattern on the Winthrop shape, has a quarter inch brown line edging the rim with shaded tones of brown gradually spreading to a very pale color at the outer edge of the plate. **Onondaga Pottery Co., Dept. MH, Syracuse 4, N.Y. (Key No. 183)**

Wet and Dry Vacuum Cleaner

The Finnell Model 10B Wet and Dry Vacuum Cleaner features a by-pass motor to assure against grounds when picking up suds or dust. Neither dust nor moisture can injure the motor since the vacuum air stream does not pass through it. The motor is kept cool during prolonged periods of operation by a separate fan. A 1 h.p. motor operates the machine quietly and it is easily moved on ball-bearing swivel casters.

The new model is light in weight and readily portable but sturdily constructed for heavy-duty work. It has 12 gallons wet capacity and 1⅓ bushels dry capacity for long operation before emptying is required. Accessory tools are available for various needs including cleaning overhead pipes, grills, venetian blinds, air filters and other difficult areas. The unit has vinylite finish inside to resist corrosion and has outside finish of baked enamel. Hose connections are non-rusting swivel type with positive

lock. **Finnell System, Inc., Dept. MH, Elkhart, Ind. (Key No. 184)**

Metlwal Partitions

Low initial cost, permanent economy, easy maintenance, quiet, fire resistance and rich attractive appearance are some of the features claimed for the new Series "600" Metlwal Partitions. This new partition and paneling material is designed for use in new construction or modernization and incorporates special utility and convenience features. It offers clean, fast, simple installation of permanent partitions and paneling which can be moved without waste when floor plans change. Standard panels and parts combine to make custom built installations as needed as standard panels may be cut and fitted like lumber.

The new material is available in natural wood grain finishes and all parts are Bonderized for rust resistance and long wear. Double wall construction gives effective sound control and provides dead air space for insulation and for concealed utilities. Removable base sections facilitate wiring and piping and standard electrical outlets and grilles can be used in any location and number desired. Parts may be used interchangeably for partitions and paneling and the new Series "600" Metlwals give a rich, clean, attractive finish to walls of offices, corridors, waiting rooms and other areas. **Martin-Parry Corp., Dept. MH, Box 964, Toledo 1, Ohio. (Key No. 185)**

(Continued on page 224)

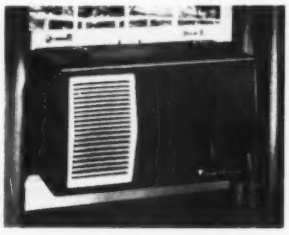
Koroseal Tile

Koroseal Tile Special and Koroseal Tile Deluxe are two new weights of vinyl plastic tile which have been added to the Sloane-Blabon line of Koroseal floor tile. Koroseal Tile Special is a flexible, vinyl plastic floor covering with a durable surface that is easy to keep clean. It is nonporous and resistant to dirt, stains and alkalies. It is available in 9 by 9 inch size in six colored marble effects, and is economical in price.

Koroseal Tile Deluxe is a vinyl plastic floor covering with Neofelt backing. It has a nonporous glossy surface that is easy to maintain and is recommended for installation in areas where traffic is heavy. It is available in 9 by 9 inch size and comes in eight colors. **Sloane-Blabon Corp., Dept. MH, 295 Fifth Ave., New York 16. (Key No. 186)**

Room Air Conditioner

Two new room air conditioning units feature an all-weather control panel, finger-tip directional air control and finger-tip fresh air intake. Model 712 has ½ ton capacity for cooling rooms up to 300 square feet. Model 734, with ¾ ton capacity, will cool areas up to 450 square feet. Two-speed controls permit high or low air discharge and the design permits directing the air from the front or side of the window type unit. Both models are 28¾ inches wide, 16-5/16 inches high and project 13¼ inches into the room. The heavy-gauge bonderized



cabinets are finished in baked gray and cream enamel. **Fresh'nd-Aire Co., Dept. MH, 221 N. La Salle St., Chicago 1. (Key No. 187)**

Royal treatment in the patient room

Presenting—an important advance in modern hospital furniture

Your professional recommendations played a major part in making Royal's new line of metal hospital furniture the finest ever produced. Here is new functional beauty . . . new strength and durability . . . new ease of maintenance . . . and a whole new range of therapeutic hospital colors.

Thus Royal's new modern design, technical developments, and therapeutic colors produce hospital furniture that cheers a patient and becomes a positive aid to nursing and treatment.

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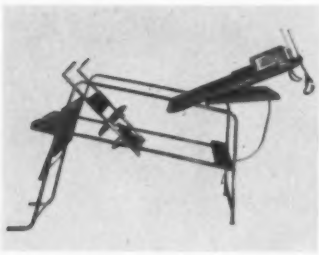
What's New . . .

Examination-Treatment Table



The Eder-McClure Combination Table is designed to be used for routine patient examination and, by easy conversion, for proctoscopic treatment or examination. The light weight table can be easily converted by the nurse in a few seconds for the use required. The correct anatomical position is easily assumed by the patient and firm support is given by shoulder pads, chest and head bands.

The table has a step for patient use in getting up on the table. Stirrups can be moved in any direction and one section of the table is adjustable from 45 degrees above horizontal to 50 degrees below. It is raised with finger-tip pressure, lowered by pressing the release lever, and locks instantly in the desired position. The McClure Cradle for sigmoidoscope and anorectal examinations makes it impossible for the patient to move away once he is in position and gives the patient secure support where required.

The table is leatherette upholstered for long wear and easy cleaning, has sanitary, comfortable padding, and the frame is welded steel tubing, triple chrome plated. **Eder Instrument Co., Dept. MH, 2293 N. Clybourn Ave., Chicago 14, (Key No. 188)**

Horner Fomentation Cloth

Made of pure virgin wool face with a cotton back, the Horner Knitted Fomentation Cloth is perfectly constructed for hot foments. It is knitted with all the virgin wool on one side and the cotton on the reversible side. The combination knit provides exceptional insulating qualities so that the cloth retains heat for long periods of time. It is soft and comfortable for the patient and can be reused indefinitely.

Since the Horner Fomentation Cloth is a complete unit, it saves time and effort in the sewing and planning rooms. It is 56 inches wide and can be cut to any desired size, shape or length. The cloth is heated in the sterilizer, run quickly through the wringer to remove excess water and applied with the soft wool side next to the body. **Horner Woolen Mills Co., Dept. MH, Eaton Rapids, Mich. (Key No. 189)**

Floor Tile Patterns

ThemeTile, the patterned floor tile, is now available in four new colored designs. The new decorative designs harmonize with the plain and marbleized colors in which Kentile asphalt title is made and with Kentile feature strip and Kenbase in five colors each. The new ThemeTile is made in standard 9 square inch size, precision die cut with the pattern going all the way through the tile. **Kentile, Inc., Dept. MH, 58 Second Ave., Brooklyn 15, N. Y. (Key No. 190)**

Posting Tray

The new Norfield Posting Tray offers maximum security of contents while permitting easy handling. It is fully adaptable, taking cards of different widths by using the adjustable guide. The guide folds down to permit offsetting. Light in weight, the tray is easily portable and holds 1000 cards in easy reach. Wide angle opening permits

full visibility of sheets. The tray has been under development for three years and has been tested and proved in actual use. **Physicians' Record Co., Dept. MH, 161 W. Harrison St., Chicago 5. (Key No. 191)**

Milk Dispenser

A new fluid milk dispenser is being introduced that serves milk in measured amounts. A dial is set, the glass or cup placed in position, a button pressed, and an exact quantity of milk is dispensed. The unit will handle glasses, paper cups, milk shake cans and other types of containers.

The amount of milk served can be changed as desired merely by turning a dial. Milk remains in the sealed, sterile can until served. It does not touch the dispenser or valve assembly because of the single-service tube. Complete sanitation is maintained by the Norriseal can and the tube which are an integral part of the new machine. **Norris Dispensers, Inc., Dept. MH, 2726 Lyndale Ave. So., Minneapolis 8, Minn. (Key No. 192)**

(Continued on page 226)

Sectional Cafeteria Equipment

Flexibility of arrangement and economy are features of the new Silvercraft sectional units for food serving and food preparation. The line consists of plain units, steam table units, cold pan units, griddle units, urn stand units and several refrigerated units. With the basic sections rolled doors, roller drawers, shelving and other accessories are available to make up complete units for cafeteria counters, back-bar counters, food serving counters, or as individual units.

Units are available in 3, 4, and 5 foot lengths, each 2 feet wide and 34 inches high. Working surfaces are stainless steel or sectional maple and cabinet bodies are of furniture steel. Units and fittings are of welded construction and bodies are pre-punched for easy assembly. They are available in baked enamel hammerloy finish in white and four colors. **Silvercraft, Inc., Dept. MH, P. O. Box 107, Louisville 1, Ky. (Key No. 193)**

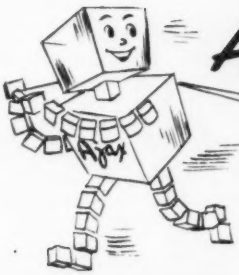
Atatrol Feeding Valve

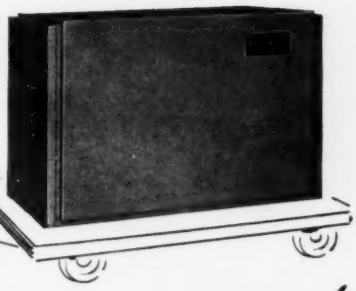
A new feeding valve has been designed to improve the performance of rubber nipples and to eliminate many of the problems found in bottle feeding of infants. The Atatrol Feeding Valve has been tested extensively at Baylor University College of Medicine and is designed to protect the infant from slow feeding, colic and incessant crying caused by hunger, as well as from vomiting, gagging and other problems resulting from bottle feeding. It controls the flow of fluid from the nipple so that fluid comes out when the baby is suckling, but stops while he is relaxing. The right amount of fluid is released automatically. While the infant relaxes, the spring allows the valve to open momentarily and the fluid from the bottle replenishes itself into the nipple.

The Atatrol Feeding Valve is made of nylon, aluminum and stainless steel and consists of a valve with a disc and a small center spring. It can be used with

most nipples and can be sterilized with nipples and bottles. **Martin-Universal, Inc., Dept. MH, 185 N. Wabash Ave., Chicago 1. (Key No. 194)**

The AJAX ICEMAN comes but once...





the ICE is yours FOR KEEPS!

available in separate units according to need

1 ICEMAKER
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132 cubes at a time . . . dry and cold . . . crystal clear . . . 200 lbs. of ice in a day's time . . . when you want it . . . where you want it . . . **Say when!**

What more could you ask? Crystal clear ice cubes, cold and dry . . . insulated storage bin, capacity 110 lbs. . . . automatic, positive cut-off when bin is filled . . . hermetically sealed freezing system, no condenser to clean . . . dependable Servel compressor, proved by years of experience, in thousands of installations.

IF you have a satisfactory ice storage bin, the AJAX Electric Iceman will fill it for you . . . and replenish the supply as needed . . . automatically . . . without fuss, muss or bother . . . for about one-tenth of your present cost of bulk ice!

Only from AJAX can you get such convenience and such economy. Because only the new AJAX "Challenger" (Model A3W-1) is available in sections, according to your needs: the ice cube maker, the ice crusher, the ice storage chest (with or without legs).

Why delay? The coupon is for your convenience.

Manufactured by Servel, Inc.

Here are other AJAX Models, for other requirements . . . making over two million pounds of ice every day, on the premises of satisfied owners. Model A5A-4 (left) capacity over 300 lbs. of ice cubes daily. Model AF150 (right) makes ice flakes instantly, up to 1500 lbs. capacity.

PIN THIS COUPON TO YOUR LETTERHEAD!

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2509 Washington Ave. — Evansville, Ind.

Tell me more about the Ajax Electric Iceman Model A3W-1

Name.....Title.....

Would like to have information also about

- ☐ AJAX Electric Iceman Model A5A-4
- ☐ AJAX Electric Ice Flaker Model AF150

What's New . . .

Bio-Sorb Dispenser-Package

Bio-Sorb Absorbable Powder is now distributed in a package designed to be used as a wall dispenser. Each package-dispenser holds 288 packets of Bio-Sorb. Hung on the wall by a tab designed for that purpose, the package is so made that individual packets of Bio-Sorb are easily dispensed from the bottom of the dispenser. Bio-Sorb is still available in five pound canisters for powdering gloves prior to sterilization. **Ethicon Suture Laboratories Inc., Dept. MH, New Brunswick, N.J. (Key No. 195)**

X-Ray Film Cooler

The new Bar-Ray water cooler is especially designed for x-ray film processing. Only 18 by 18 by 12 inches in size, extremely compact, the unit meets the load requirements of the average film processing system. The unit is easily installed under or adjacent to tank, in or out of the darkroom, and provides automatic delivery of water at 68 degrees F. It provides complete water cooling and the hermetically sealed container has a five year guarantee by the manufacturer. It is available with cabinets of working height, doors and tops of stainless steel, and operates on 110 volts, 60 cycles A.C., single phase. The cooler is supplied in 22, 50, 66, 100, 135 and 180 gallon capacities. **Bar-Ray Products, Inc., Dept. MH, 209 25th St., Brooklyn 32, N. Y. (Key No. 196)**

Liquid Duplicator

The new Model L-45-2 Copy-rite Liquid Duplicator is modernized in appearance and incorporates many new features over the L-45 which it replaces. A new automatic master lock permits the operator to open the drum lock to receive master copy by merely turning the handle in reverse. Turning the handle in the operating direction automatically closes the lock and secures the master, ready for operation.

A new receiving tray with improved design to provide better paper stacking is also incorporated. New paper guides simplify the method of positioning to accommodate various widths of paper stock and better gripping of copy paper. **Wolber Duplicator & Supply Co., Dept. MH, 1203 Cortland St., Chicago 14. (Key No. 197)**

Leveleze Roof Drain

The new Josam Leveleze Roof Drain is so designed that alterations are not necessary because of miscalculations in roof levels. The adjustable top of the drain can be raised or lowered to the proper elevation. Should the roof level be changed at any time, the drain can be easily adjusted. The body can be installed in the rough slab to act as a drain during construction and prior to finishing the roof and insulation. After insulation the adjustable collar can be fitted to meet any thickness and to provide finished roof drainage. The new drain also has the Josam combined dome strainer and sediment cup and non-puncturing flashing clamp device and gravel stop. **Josam Mfg. Co., Dept. MH, Michigan City, Ind. (Key No. 198)**

Traditional Room Furniture

In addition to its new modern line of patient room furniture, Marshall Field and Company has brought out an attractive suite in traditional design. The period styling of the Traditional Suite makes it especially adaptable for use in private rooms and the new wood line is available in Cherokee Mahogany or Claret Mahogany.

The furniture is designed for patient comfort and for attractive appearance, yet it is durably constructed and finished for long wear. The traditional design is carried out in all pieces including the bed, which is equipped with multiple position two-crank gatch spring, the bedside cabinet with towel bar and basin ring, overbed table, with reading stand, mirror and vanity section, dresser and mirror, cushioned guest chair, upholstered pull-up chair, screen and footstool. **Marshall Field & Co., Contract Div., Dept. MH, Merchandise Mart, Chicago 54. (Key No. 199)**

(Continued on page 228)

Electronic Humidity Control

The new Barber-Colman Electronic Humidity Control provides two-position or proportioning humidifying or dehumidifying for process or comfort control. It features instant response with plug-in element, wide range and simple adjustments. With a central fan, the sensing element is mounted either in a duct or in the conditioned space. For controlling the relative humidity in spaces not completely air conditioned, the aspirating type control is available with all operating adjustment mechanisms mounted in a cabinet. **Barber-Colman Co., Dept. MH, Rockford, Ill. (Key No. 200)**

Fire Detection Alarm System

Moderate price and accuracy are features of the new Atmo system of fire detection and alarm especially applicable for institutional installations. The system is approved by Underwriters' Laboratories and meets all requirements of state laws for alarm systems in public buildings, according to the manufacturer.

Working on the temperature rate-of-rise principle, the system is highly flexible. Tubing mounted on the ceiling of the room terminates at a detector. Any continued undue temperature rise, such as fire produces, actuates the detector which sounds the alarm. Features which eliminate the possibility of false alarms are incorporated in the detector's design.

The system can be installed without marring interior decoration, regardless of the type of design of the building. Tubing can be painted to match room color schemes without losing its detecting effectiveness. Detection can be zoned to give the exact location of the danger, so that extinguishing equipment can be brought into immediate use. If desired,

the alarm circuit can be connected to a municipal fire headquarters. **Walter Kidde & Co., Inc., Dept. MH, 675 Main St., Belleville 9, N. J. (Key No. 201)**

What's New . . .

Oxygen Analyzer

The Melco Oxygen Analyzer is a portable unit which gives a continuous reading of the concentration of oxygen. It is an electronic instrument which utilizes standard current, is unaffected by temperature variations or outside humidity conditions and in which accuracy is not impaired by line voltage fluctuations. It provides a practical, accurate means of correlating therapeutic response to varying oxygen concentrations. No special skills are required for its operation.

The instrument is a sturdy, heavy duty unit built to withstand everyday hospital use. It is completely versatile and may be used with equal ease and accuracy with tents and incubators. The sturdy aluminum construction makes the unit light in weight for easy portability and so that it can be placed on top of the incubator or tent which is to be analyzed. It can be immediately put into operation in five easy steps and gives almost complete control over oxygen therapy. **Melchior, Armstrong, Dessau Co., Inc., Dept. MH, Ridgefield, N. J. (Key No. 202)**

Laminex X-Ray Cassette

The new Picker Laminex X-Ray Cassette will not warp. It is similar in appearance to other models and requires no change in technic and has the same radiographic transparency. It is lighter in weight and has the same durable, easily cleaned surface. It will resist a lighted cigarette and can be wiped clean with a cloth to a glossy finish.

All features of the regular Picker cassettes, including "floating cover," offset hinges and easy locking springs have been incorporated into the new Laminex cassettes. Only 14 by 17 inch cassettes will be supplied with the Laminex front, since warpage is not a problem in the smaller sizes. **Picker X-Ray Corp., Dept. MH, 25 S. Broadway, White Plains, N. Y. (Key No. 203)**

Cellu-Tone Satin Paint

Cellu-Tone Satin is a new paint for walls, woodwork and furniture. It is neither an oil nor a synthetic, latex-type paint, dries with a low luster, is unaffected by grease or smoke and is highly resistant to moisture. Pencil marks, ink, mercurochrome, lipstick and crayon marks are easily removed by washing. The paint can be washed again and again and is therefore especially effective in kitchens and bathrooms. One coat of Cellu-Tone Satin is usually sufficient and it requires no primer on either new or old work. It is marketed in 14 modern colors. **Pratt & Lambert, Inc., Dept. MH, 75 Tonawanda St., Buffalo 7, N. Y. (Key No. 204)**

Towel-Dispensing Cabinet

Pre-testing of the new Push Button Control Turn-Towl dispensing cabinet indicates a reduction in towel consumption of up to 50 per cent with its use. The dispenser is designed for use with Mosinee Turn-Towls, a pure sulphate towel available in roll form.

The new dispensing cabinet is easy to operate yet provides a desirable control to discourage waste of towels. When a button is pushed in front of the cabinet and a small crank at the side of the cabinet is turned, a single towel is dis-

pensed. Since Mosinee towels are rapidly absorbent, strong and soft-textured, a second towel is seldom necessary. The cabinet is ruggedly constructed for hard use and the dispensing mechanism is completely removable as a unit in case of damage. **Bay West Paper Co., Dept. MH, Green Bay, Wis. (Key No. 205)**

Fountain Freezers

Several new models in five-gallon fountain freezers have been added to the Sweden line. Model 1-98 is a heavy duty hard ice cream freezer with a capacity of five gallons per batch and a freezing time of seven minutes. Model 1-99 is a light duty, batch freezer with automatic controls for volume production of the soft-served product. It also has a capacity of five gallons per batch and an approximate freezing time of ten minutes. A new heavy duty automatic continuous freezer, Model 1-200, has a five gallon head and a capacity of 25 gallons per hour. **Sweden Freezer Mfg. Co., Dept. MH, 3401 17th Ave. W., Seattle 99, Wash. (Key No. 206)**

(Continued on page 230)

Steel Shelving and Cabinets

A complete new line of quality steel storage shelving, library shelving, counters, storage cabinets and machine stands is now available from Royal Metal. The line is completely adjustable to any needs, parts are easily assembled with a minimum of bolting required, adjustments can be made without tools and the parts are packaged in standard units to simplify planning and purchasing. U. S. Standard sheet steel gauges are used in all equipment. Included in the new shelving are open and closed type shelving, box inserts, sectional steel counters, office record storage equipment and tab card cabinets. **Royal Metal Mfg. Co., Dept. MH, 175 N. Michigan Ave., Chicago 1. (Key No. 207)**

Hudson Craftsmen Furniture

A new line of California furniture has been designed by Richard Edson Riddle, young California furniture stylist, for commercial and professional applications. Employing Laminated Bentwood and upholstery materials in designs of applied functionalism, the new line combines comfort with a light airy appearance. Laminated Bentwood is developed by a process of forming and laminating hardwood. The exposed laminated parts are selected Eastern Birch. Interior woods are all solid hardwood, carefully dowelled and glued for strength and long wear. Specially-treated metal bolt fastenings are used for structural strength. Foam rubber and spring construction gives maximum comfort and resilience to seating.

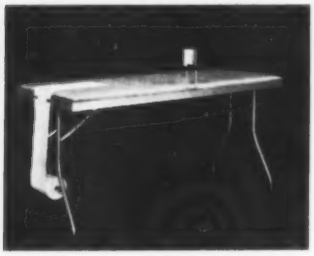
The new line includes 14 selected designs in side and arm chairs, sectional groups, two and three place settees and several styles of tables, many with Formica tops. Wood finishes are available in a wide variety, ranging from natural through walnut and mahogany stains to brilliant lacquered colors. Upholstery is available in a variety of colors, patterns and fabrics. The new line should be particularly adaptable for reception

rooms, nurses' homes and other areas. **The Hudson Craftsmen, Dept. MH, 5950 Avalon Blvd., Los Angeles 3, Calif. (Key No. 208)**

What's New . . .

Blood Bank Table

A folding table is available which can be quickly set up for donors when needed in a blood bank and folded out of the way when not in use. The table is



6 feet long, 30 inches wide and 34 inches high. It is padded and has a rack at the head for a roll of paper towels and racks on each side for blood container brackets. The tables can be used in mobile units as they stack together in minimum space.

Also available are folding tables 24 by 24 inches and 30 by 30 inches for use between beds for instruments and other accessories in blood donor rooms. **Foldcraft, Incorporated, Dept. MH, 825 Glenwood Ave., Minneapolis 5, Minn. (Key No. 209)**

Heat-Absorbing Glass

Aklo Fine-tex is a new heat-absorbing, glare-reducing patterned glass designed to provide "filtered daylight." It will be available in ⅛ inch and ¼ inch thicknesses and may also be had in ¼ inch wired form for skylights and fire retardant glazings. The Aklo glass filters out more than three times as much sun heat as ordinary glass of the same thickness, according to tests. The new Aklo Fine-tex is a finely-textured pattern providing a more decorative surface with light-diffusing characteristics. **Libbey-Owens-Ford Glass Co., Dept. MH, Nicholas Bldg., Toledo 3, Ohio. (Key No. 210)**

Plastikspray Process

The new Plastikspray Process provides a tough, sanitary, washable, colorful and attractive coating for wall and ceiling areas in many parts of the hospital. It consists of spraying a liquid vinyl plastic of the Cocoon family on any kind of surface, to which it will adhere permanently, forming a flexible jointless plastic sheeting. While the cost of the process is not inexpensive, it is less than that of cemented-on vinyl plastic coverings.

The process results in a hard, resilient, durable finish which will stand up under hard wear in heavy traffic areas such as halls, corridors and auditoriums; where there is steam or condensation as in laundries, kitchens, sterilization rooms, bath and hydrotherapy rooms, refrigerators and other areas; in air conditioned areas where extreme sanitation is required as in the surgery, central sterile supply and autopsy rooms; in patients' rooms where frequent reconditioning is required, and in dark rooms, x-ray rooms and laboratories where acid or radio-active conditions occur. The finish can be washed, steam-cleaned, applied as strippable film or pigmented with lead powder to bar radiation. The company also supplies a new type of inexpensive, highly resilient flooring made by spraying vinyl plastic on ½ inch felt. The resulting product has the softness of carpeting and approximately the same wearing qualities as linoleum.

The process can be supplied in any one of a number of colors, protects against corrosion, is waterproof and nonporous, does not support combustion and is stainproof, acidproof and fungi-resistant. **Progressive Industries, Inc., Dept. MH, 48-08 Van Dam St., Long Island City 1, N. Y. (Key No. 211)**

Colostomy Protector Pouch

The new United Colostomy Protector Pouch Unit is a lock-tight, feather-light appliance with disposable bags for security after irrigation. The disposable bags, washable face-plate and ring make it possible to keep the entire unit scrupulously clean. The locking-ring is designed to fit the contours of the body and to be adjusted for individual fit. The unit can

be worn with assurance since it causes no bulge under clothing and permits no odors to seep out. **United Surgical Supplies Co., Dept. MH, 160 E. 56th St., New York 22. (Key No. 212)**

Surgical Sponge Implants

A new polyvinyl plastic sponge has been announced for surgical implants. The Ivalon Surgical Sponge acts as a framework within the body for the growth of new fibrous tissue. It has been successfully used in reenforcing abdominal aneurysms considered beyond surgical repair and has also been used for packing the extrapleural space to prevent infection. Studies show the sponge to be non-inflammatory and nonreactive. It is readily adjustable to forming and shaping. **Clay-Adams Co., Inc., Dept. MH, 141 E. 25th St., New York 10. (Key No. 213)**

Pharmaceuticals

Co-Pyronil

Co-Pyronil is a new antihistaminic combination having exceptionally long duration of effect. Tests conducted with Pyronil during the 1951 hay-fever season indicated superior results in a majority of cases with side-effects on effective therapeutic doses usually negligible. The drug is slow in onset of action. Combined with fast-acting Thenylpyramine and Cyclopentamine, to form Co-Pyronil, it gives a formula for prompt action followed by prolonged relief. **Eli Lilly & Co., Dept. MH, Indianapolis 6, Ind. (Key No. 214)**

Cortrophin

Cortrophin is an improved form of Organon's adrenocorticotropic hormone preparation. It is indicated in the treatment of all stressful conditions which respond to ACTH therapy. It is supplied in two strengths: 25 U.S.P. unit vials and 40 U.S.P. unit vials, each packaged with a 5 cc. vial of a special Cortrophin solvent for greater ease in varying the dosage. The reconstituted Cortrophin solution remains stable for at least a month at room temperature. **Organon Inc., Dept. MH, Orange, N. J. (Key No. 215)**

Hibicon

Hibicon is a new anti-epileptic compound which has shown best results against the grand mal type of epilepsy. For oral administration, clinical tests have indicated that the drug is well tolerated and that it is effective in cases where other anti-convulsants have failed. It is a new compound with a chemical nucleus never before used in the treatment of epilepsy and its full possibilities are not yet known. **Lederle Laboratories Div., American Cyanamid Co., Dept. MH, 30 Rockefeller Plaza, New York 20. (Key No. 216)**

Butazolidin

Butazolidin is a new, synthetic, orally effective agent for the treatment of arthritis and allied disorders. It is a pyrazolone derivative, unrelated to the steroid hormones, which was first synthesized in the laboratories of the Geigy Company in 1948. After thorough pharmacologic testing, it was issued to a selected group of rheumatologists for clinical evaluation. Favorable results with toxicity of a low order have been reported. The product will be issued as oral tablets of 100 and 200 mg. **Geigy Co., Inc., Dept. MH, 220 Church St., New York 13. (Key No. 217)**

What's New . . .

Hyazyme

Hyazyme is the Abbott name for hyaluronidase, an enzyme which accelerates the diffusion and absorption of subcutaneously injected fluids and drugs. It is a white lyophilized powder which becomes a clear solution when dissolved in water for injection or normal saline solution. It is supplied in 1 cc. vials. **Abbott Laboratories, Dept. MH, North Chicago, Ill. (Key No. 218)**

Injection Wyamine Sulfate

Injection Wyamine Sulfate is designed to increase blood pressure safely in emergencies resulting from a state of shock. It is a vasoconstrictor drug chemically and pharmacologically related to other known pressor amines. Clinical studies have determined that Wyamine produces the desired results without causing undesirable side effects. It is recommended to produce a temporary rise in blood pressure when the latter is seriously depressed, as in shock following coronary thrombosis, or occuring during surgical procedures, or after administration of spinal anesthesia. **Wyeth Incorporated, Dept. MH, 1600 Arch St., Philadelphia 3, Pa. (Key No. 219)**

Trilene

Trilene is a potent analgesic for inhalation analgesia for obstetrics, which is nonexplosive, non-inflammable in air and can be self-administered with complete safety. Trilene produces relief of pain without loss of consciousness or with only momentary unconsciousness and may be used with ease and efficiency. It can also be used in a variety of normally painful minor surgical procedures. It is self-administered with an inhaler as a mixture with air and oxygen. It may also be administered in standard anesthetic machines in conjunction with nitrous oxide and oxygen or other agents to ensure analgesia in prolonged procedures where only light planes of anesthesia are required. **Ayerst, McKenna & Harrison Ltd., Dept. MH, 22 E. 40th St., New York 16. (Key No. 220)**

Aquasol E

Aquasol E is an aqueous vitamin E provided in capsules or drops. It is rapidly absorbed and fully utilized and is indicated in threatened and habitual abortion, the menopause, fibrositis, selected types of peripheral vascular disease and for adjunct treatment of diabetes. The capsules are supplied in bottles of 100, 500 and 1000 and the drops in bottles of 15 and 60 cc. with dropper. **U. S. Vitamin Corp., Dept. MH, 250 E. 43rd St., New York 17. (Key No. 221)**

Product Literature

• **"Answers to 63 Questions on Cleaning in Hospitals and Institutions"** is the title of a new 32 page booklet published by Oakite Products, Inc., 118A Rector St., New York 6. The booklet discusses materials and procedures for performing 63 cleaning and allied operations in hospitals and institutions based on successful experience in leading institutions. It is divided into three main sections: Dietary Department and Main Kitchen; Housekeeping Department, and Engineering and Maintenance Departments. A preface entitled "The Science of Cleaning" presents some interesting facts. **(Key No. 222)**

• The entire line of **non-absorbable sutures** offered by Gudebrod Bros. Silk Co., Inc., 225 E. 34th St., New York 1, is described in a new folder. Featured is information on Champion Serum Proof Silk sutures. **(Key No. 223)**

• The new **Institutional Bedding Catalog No. 52** issued by A. Brandwein & Co., 24th and S. State Sts., Chicago 16, contains information on the line of products especially engineered for institutional needs. Included is information on Strene processed mattresses for complete vermin control, and institutional foam rubber mattresses. **(Key No. 224)**

• How **Lapidolith,** the patented chemical concrete hardener, makes concrete floors dust-free and up to ten times harder, is discussed in bulletins issued by L. Sonneborn Sons, Inc., Building Products Div., 80 Eighth Ave., New York 11. **(Key No. 225)**

• **Supplement "1" to Catalog LP31** on **Laboratory Glassware** is now available from Corning Glass Works, Laboratory and Pharmaceutical Sales Dept., Corning, N. Y. Included is information on new items in Corning, Pyrex and Vycor glassware for laboratories. **(Key No. 226)**

• **"Vertical Transportation by Otis"** is the title of a new 24 page brochure describing the complete line of Otis equipment and services for vertical transportation. Separate sections describe passenger and hospital elevators, dumbwaiters, freight elevators and elevator modernization and maintenance programs. The text is illustrated by photographs and line drawings and 17 tables provide dimensions and engineering data. The booklet is available from Otis Elevator Co., 260 Eleventh Ave., New York 1. **(Key No. 227)**

• Complete specification and price information on Cory Automatic Push-button Coffee Brewing Systems, Grinders and other equipment are given in a new 8 page **Commercial Catalog** released by the Cory Corporation, 221 N. La Salle St., Chicago 1. **(Ke y No. 228)**

• Visitors, in hospitals equipped with the Dahlberg Hospital Pillow Radio, can give inexpensive gifts to patients through use of the **"Get Well" cards** now available through The Dahlberg Company, Hospital Pillow Radio Service, Golden Valley, Minneapolis 22, Minn. Cards are designed for new mothers, for women and for men patients. Each is attractively illustrated with instructions to the visitors on their use. Dimes may be inserted on the inside portion of the card for delivering or mailing to the patient and each dime gives him a full hour of radio playing time of his own choice. Cards and posters are provided to hospitals at no cost under the Dahlberg plan which turns over 25 per cent of the total radio earnings to the hospital each month. **(Key No. 229)**

• Literature available on G-11® brand of hexachlorophene is listed in a revised, comprehensive bibliography published by Sindar Corporation, 330 W. 42nd St., New York 36. Known as **Technical Bulletin H-1,** it contains references and abtracts of scientific and trade articles and abstracts of patents. The bulletin is indexed for reference concerning the use of G-11® as a germicide in soap, synthetic detergents and various materials. **(Key No. 230)**

• **"Fenestra Hollow Metal Doors, Swing and Slide,"** is the title of a new 16 page catalog recently released by Detroit Steel Products Co., 2250 E. Grand Blvd., Detroit 11, Mich. The catalog is profusely illustrated with pictures of the types and sizes of Door-Frame-Hardware units in the Fenestra line and gives installation instructions, descriptions, uses and specifications. Emphasis is given to the economy of the units through low first cost, minimum installation costs and low maintenance. **(Key No. 231)**

• A new 4 page bulletin on **"Special Maintenance Coatings"** has been issued by United Laboratories, Inc., 16801 Euclid Ave., Cleveland 12, Ohio. It describes the use of various products for rust prevention, painting over damp areas, weatherproofing and decoration of exterior masonry, interior waterproofing and other special maintenance work. **(Key No. 232)**

• The comprehensive line of maintenance equipment and supply items manufactured and distributed by The Churchill Mfg. Co., Galesburg, Ill., is described and illustrated in the new 64 page 1952 catalog, **"Churchill Building Maintenance Programs and Products,"** recently released. The Floor Maintenance Programs section of the catalog gives detailed information on the various types of floors and the best maintenance program for each. The catalog is indexed for quick reference. **(Key No. 233)**

What's New . . .

• A new 60 page catalog of **Westinghouse-Sturtevant products on air conditioning, cleaning and handling** is now available from Westinghouse Electric Corp., Box 2278, Pittsburgh 30, Pa. Divided into an equipment section with a complete set of condensed specifications, dimensions and descriptions of Westinghouse-Sturtevant products, an application section telling how to put air to work and an engineers' data section, the catalog also has a "Quick Finder" chart to simplify the problem of selecting the right piece of equipment for the job. **(Key No. 234)**

• An informative booklet, **"Twice As Many Records In the Same Space,"** has been published by Visi-Shelf File, Inc., 46 W. Broadway, New York 7. The booklet contains data describing how more record area can be achieved with the use of the Visi-Shelf Filing System. **(Key No. 235)**

• A selection of recently released Fox and Warner feature pictures, classics and entertaining shorts is now available on 16 mm. film for rehabilitation and recreational programs. Descriptive information on this long list of films available from Films Incorporated, 1150 Wilmette Ave., Wilmette, Ill., is given in the new **"1952-53 Catalog of Outstanding 16 MM. Films."** The catalog lists these Hollywood productions under subject headings and is fully indexed. It also contains information on how to order films, rental rates and other data. The company representatives will help in planning programs to fit the audience and the budget. **(Key No. 236)**

• **"Arctic Syntex HD in Diaper Washing"** is the title of a bulletin issued by the Technical Service Division of Colgate-Palmolive-Peet Co., 105 Hudson St., Jersey City 2, N. J. It presents a report on the research work done by the company to determine the special values of Arctic Syntex HD, the new detergent, in helping to solve the problem of laundering diapers. The new product is stable in the presence of the calcium and zinc salts usually present as part of the soil in diapers. Its use cuts down the consumption of detergent and reduces the possibility of diapers developing stains, while tending to remove stains already present when diapers are repeatedly washed as outlined in the bulletin. **(Key No. 237)**

THIS COUPON is provided for your convenience in requesting additional information.

- ☐ 175 Random Pattern Tile
- ☐ 176 Rubber-Elastic Bandage
- ☐ 177 Glass Sterilizing Controls
- ☐ 178 "No-Tie" Patient's Gown
- ☐ 179 "Beaker Bouncer"
- ☐ 180 Steraject Syringe
- ☐ 181 Inductotherm
- ☐ 182 Film-Free Glass Suds
- ☐ 183 Syracuse China Designs
- ☐ 184 Vacuum Cleaner
- ☐ 185 Metlwal Partitions
- ☐ 186 Koroseal Tile
- ☐ 187 Room Air Conditioner
- ☐ 188 Combination Table
- ☐ 189 Fomentation Cloth
- ☐ 190 ThemeTile Patterns
- ☐ 191 Posting Tray
- ☐ 192 Milk Dispenser
- ☐ 193 Cafeteria Equipment
- ☐ 194 Feeding Valve
- ☐ 195 Dispenser-Package
- ☐ 196 X-Ray Film Cooler
- ☐ 197 Liquid Duplicator
- ☐ 198 Leveleze Roof Drain
- ☐ 199 Traditional Room Furniture
- ☐ 200 Electronic Humidity Control
- ☐ 201 Fire Detection System
- ☐ 202 Melco Oxygen Analyzer
- ☐ 203 Laminex X-Ray Cassette
- ☐ 204 Cellu-Tone Satin Paint
- ☐ 205 Towel Dispensing Cabinet
- ☐ 206 Fountain Freezers
- ☐ 207 Steel Shelving and Cabinets
- ☐ 208 Hudson Craftsmen Furniture
- ☐ 209 Blood Bank Table
- ☐ 210 Heat-Absorbing Glass
- ☐ 211 Plastikspray Process
- ☐ 212 Colostomy Protector Pouch
- ☐ 213 Surgical Sponge Implants
- ☐ 214 Co-Pyronil
- ☐ 215 Cortrophin
- ☐ 216 Hibicon
- ☐ 217 Butazolidin
- ☐ 218 Hyazyme
- ☐ 219 Injection Wyamine Sulfate
- ☐ 220 Trilene
- ☐ 221 Aquasol E
- ☐ 222 "63 Questions"
- ☐ 223 Non-Absorbable Sutures
- ☐ 224 Bedding Catalog
- ☐ 225 Lapidolith Booklets
- ☐ 226 Laboratory Glassware
- ☐ 227 "Vertical Transportation"
- ☐ 228 Commercial Catalog
- ☐ 229 "Get Well" Cards
- ☐ 230 Bibliography on G-11
- ☐ 231 "Fenestra Doors" Catalog
- ☐ 232 "Special Maintenance Coatings"
- ☐ 233 1952 Catalog
- ☐ 234 Westinghouse-Sturtevant Products
- ☐ 235 "Twice As Many Records"
- ☐ 236 Catalog of 16 MM. Films
- ☐ 237 "Diaper Washing" Bulletin
- ☐ 238 "Hotel Linens"
- ☐ 239 "Introduction to Acarology"
- ☐ 230 Books

I should also like to have information on the following products

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_____

NAME **TITLE**

HOSPITAL

STREET

CITY **ZONE** **STATE**

MAIL TO Readers' Service Dept., The Modern Hospital Publishing Co., Inc. 919 N. Michigan Ave., Chicago 11, Ill.

Book Announcements

Bradley, "Hotel Linens, Their Purchase, Care and Laundering," 22 pp. manual, $1.50. **American Hotel Assn., Dept. MH, 221 W. 57th St., New York 19. (Key No. 238)**

Baker and Wharton, "An Introduction to Acarology," 465 pp., $10. **The Macmillan Co., Dept. MH, 60 Fifth Ave., New York 11. (Key No. 239)**

Leahy and Bell, "Teaching Methods in Public Health Nursing," 220 pp., $3.50. Haynes and McGuire, "Textbook of Neurosurgical Nursing," 178 pp., $3.50. **W. B. Saunders Co., Dept. MH, W. Washington Square, Philadelphia 5, Pa. (Key No. 240)**

Suppliers' News

Libbey Glass, division of Owens-Illinois Glass Co., Toledo 1, Ohio, announces the opening of a new branch office in Seattle, Washington. The new office will be managed by **Donald A. Marquis.**

McKee Glass Co., Jeannette, Pa., manufacturer of Coffee Hottles and other glass cooking utensils, has been taken over by **Thatcher Glass Mfg. Co. of Elmira, N. Y.,** manufacturer of glass food and beverage containers, as a division of that company.

The Nestle Co., Inc., processor of chocolate and other food products, announces change of address from **Colorado Springs, Colo.** to **2 William St., White Plains, N. Y.**

Sharp & Dohme, Inc., 640 N. Broad St., Philadelphia 1, Pa., manufacturer of pharmaceuticals and biologicals, announces the opening of a new building for its **Minneapolis branch at 1301 Bryant Ave. No.,** to replace its former location at 607 Fifth Ave. So. with larger space to meet the expanding requirements of the area.

Printed in U. S. A.

PREFERRED for CASSEROLE COOKERY

The chef who takes pride in his recipes knows that the full flavor is preserved if preparation and serving is done in Hall ware. Hall China lasts longer . . . cannot absorb . . . is easy to clean . . . keeps its fresh new look permanently. It is the only china made by our single-fire process which inseparably fuses body, glaze, and color.

Write on company letterhead for Catalog 48 which lists almost 1,000 different Hall China items and contains a color chart of the 26 beautiful underglaze colors that are available.

THE HALL CHINA COMPANY · EAST LIVERPOOL, OHIO

The World's Largest Manufacturer of Fireproof Cooking China

Hall China casseroles are available in sizes ranging from individual to banquet service.

Each Hall Casserole is individually hand finished, by a skilled craftsman, before glaze is applied.

STANTON & HILLIER
architects

GEO. WAGSCHAL & ASSOCIATES
mechanical engineers

W. E. WOOD COMPANY
general contractors

DAVIS BROTHERS, INC.
plumbing contractors

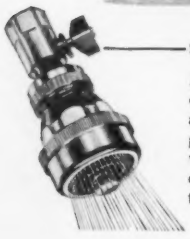
AMERICAN-STANDARD
plumbing wholesalers

OAKWOOD HOSPITAL, Dearborn, Michigan, provides maximum ease of professional and supply services to patients, with minimum physical effort by personnel. As shown in floor plan (left) both steps and time are saved.

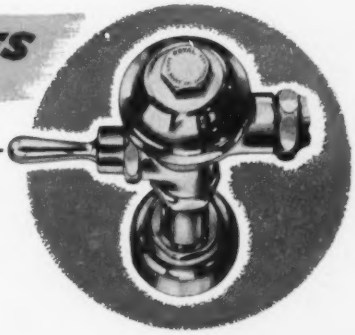
ENTHUSIASTIC APPLAUSE FROM NURSES

That precious commodity known as nurses' steps was a major factor in the planning of the new Oakwood Hospital, Dearborn, Michigan. By adopting an offset cross plan, with relatively short nursing wings converging at a central elevator core, greatly reduced nurses' travel was effected. Two nursing stations face the central core, each located in its own half of the floor and adjacent to its own utility services. Each bed in two-patient rooms has its own window, and each room has lavatory and toilet. These features are typical of the high standards which dominated all of the planning, constructing and equipping of this outstanding hospital. Likewise typical of highest standards was the selection of SLOAN *Flush* VALVES for installation throughout the building—more evidence of preference that explains why . . .

more SLOAN *Flush* VALVES
are sold than all other makes combined



SLOAN VALVE COMPANY • CHICAGO • ILLINOIS



Another achievement in efficiency, endurance and economy is the SLOAN *Act-O-Matic* SHOWER HEAD, which is automatically self-cleaning each time it is used! No clogging. No dripping. When turned on it delivers cone-within-cone spray of maximum efficiency. When turned off it drains instantly. It gives greatest bathing satisfaction, and saves water, fuel and maintenance service costs.

Write for completely descriptive folder